ForwardHealth
Wisconsin serving you

Department of Health Services

Division of Health Care Access and Accountability

Wisconsin ForwardHealth Health Maintenance Organization (HMO)

Encounter Data Submission User Guide

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1 Encounter Data Submission Overview

The Wisconsin ForwardHelath Program requires HMOs to report data and reports that will be used to analyze and monitor medical utilization and ensure quality of care. These activities will rely heavily on encounter data.

To design an effective system that collects accurate and complete encounter data, the State and its contractor, EDS, first identified the State's high level needs and requirements that an encounter data set would help address. **(See Submission Contents section of this guide**). In addition, federal mandates such as the Balanced Budget Act and the Medicaid Statistical Information System (MSIS) necessitated an effective system of collecting encounter data.

The encounter data collection system is comprised of the following four components:

Submission

Editing

Reporting

Reconciliation

1.1 Examples of an Encounter

The term **"encounter"** includes the following:

1. A service or item provided to a patient through the health care system. Examples include but are not limited to:
   - **a.** Office visits
   - **b.** Surgical procedures
   - **c.** Radiology, including professional and/or technical components
   - **d.** Prescribed drugs
   - **e.** Durable medical equipment
   - **f.** Emergency transportation to a hospital
   - **g.** Institutional stays (inpatient hospital, rehabilitation stays)
   - **h.** HealthCheck screens
2. A service or item not directly provided by the HMO, but for which the HMO is financially responsible. An example would include an emergency service provided by an out-of-network provider or facility.
3. A service or item not directly provided by the HMO for which no claim is submitted but for which the HMO may supplement its encounter data set. Such services might include (HealthCheck screens for which no claims have been received), the HMO's medical chart. Examples of services or items the HMO may include are:
   - **a.** HealthCheck services
   - **b.** Lead screening and testing
   - **c.** Immunizations

   The terms "services" or "items" as used above include those services and items not covered by the Wisconsin ForwardHealth Program, but which the HMO chooses to provide as part of its managed care product. Examples include educational services, certain over-the-counter drugs, and delivered meals.

1.2 HMO Participation Requirements

1.2.1 Computer/Data Reporting System

The HMO must maintain a computer/data reporting system that meets the Department's requirements listed below. The HMO is responsible for complying with all of the reporting requirements established by the Department and with assuring the accuracy and completeness of the data as well as the timely submission of data. Records available to the Department or its designee must support the data submitted. The Department reserves the right to conduct on-site inspections and/or audits prior to awarding the Contract. The HMO must have a contact person responsible for the computer/data reporting system and in a position to answer questions from the Department and resolve problems identified by the Department in regard to the requirements listed below.

1. The HMO must have a claims processing system that is adequate to meet all claims processing and retrieval requirements specified in the Contract.
2. The HMO must have a computer/data collection, processing, and reporting system sufficient to monitor HMO enrollment/disenrollment (in order to determine on any specific day which members are enrolled or disenrolled from the HMO) and to monitor service utilization for the Utilization Management requirements of Quality Improvement that are specified in the Contract.
3. The HMO must have a computer/data collection, processing, and reporting system sufficient to support the Quality Improvement (QI) requirements described in the contract. The system must be able to support the variety of QI monitoring and evaluation activities, including the monitoring/evaluation of quality of clinical care and service; periodic evaluation of HMO providers; member feedback on maintenance and use of medical records; and monitoring and evaluation of priority areas.
4. The HMO must have a computer and data processing system sufficient to accurately produce the data, reports, and encounter data set, in the formats and time lines prescribed by the Department in this contract, that are included in the Contract. HMOs are required to submit electronic test encounter data files as required by the Department in the format specified in the 2000-2001 HMO encounter data user manual and timelines specified in the Contract and as may be further specified by the Department. The electronic test encounter data files are subject to Department review and approval before the Department accepts production data. Production claims or other documented encounter data must be used for the test data files.
5. The HMO must capture and maintain a claim record of each service or item provided to enrollees, using the 1500 Health Insurance Claim Form, UB-04, NCPDP, or other claim formats that are adequate to meet all reporting requirements of this contract. If claim records are captured electronically, all federal mandates (e.g., HIPAA) must be followed. The computerized database must be a complete and accurate representation of all services covered by the HMO for the contract period. The HMO is responsible for monitoring the integrity of the data base, and facilitating its appropriate use for such required reports as encounter data, summary utilization data, and targeted performance improvement studies.

1.2.2 System Requirements

The HMO is responsible for maintaining and complying with all of the system requirements established by the Division of Health Care Access and Accountability (DHCAA) which include the following:

1. The HMO must have a computer processing and reporting system that is capable of following or tracing an encounter within its system using a unique encounter record identification number (RIN) for each encounter.
2. The HMO reporting system must have the ability to identify all denied claim/encounters using national ANSI (claim adjustment) or NCPDP reject codes.

3. The HMO system must be capable of reporting record types, original and reversed claim detail records and encounter records.
4. The HMO system must be capable of correcting an error to the encounter record within 90 days of notification by the Department.
5. The HMO must notify the Department of all significant changes to the system that may impact the integrity of the data, including such changes as new claims processing software, new claims processing vendors and significant changes in personnel.
6. If the HMO fails to meet the contractual deadlines for data submissions or error corrections, the HMO may be assessed liquidated damages.

2 Submission Assistance

2.1 EDS – Technical Assistance

Please send all communications regarding encounter data to the HMO Support team at EDS. The HMO Support team will provide technical assistance as needed or requested to the HMOs through the following:

HMO technical workgroup meetings
E-mail correspondence
Phone, including scheduled conference calls
HMO onsite meetings

The term **"HMO Encounter Technical Workgroup"** means a workgroup composed of:

HMOs: Technical, contract administrators, claims processing, and eligibility staff, as necessary
Division of Health Care Access and Accountability staff
Division's fiscal agent contractor staff (EDS)

Please send **technical** questions to:

HMO Support
EDS
6406 Bridge Road
Madison, WI 53713
Phone: 608-221-4746 (Extensions 80431 or 80434)
Fax: 608-250-0246
E-mail: VEDSHMOSupport@wisconsin.gov

2.2 DHCAA – Content Assistance

Please direct **content** questions to:

Catherine A. Duster or Gordon Soloway
Division of Health Care Access and Accountability
1 West Wilson
Madison, WI 53713
Phone: 608-266-0760 or 608-266-2415
Fax: 608-266-1096
E-mail: catherine.duster@wisconsin.gov
gordon.soloway@wisconsin.gov

3 Submission Contents

3.1 Overview

HMOs produce a monthly submission and send it to EDS each month. The submission may include corrections from a previous month. Please note that corrections are always part of the monthly submission, and they typically are not sent alone in a separate file.

Each encounter submission must contain a header and multiple detail records as defined below. All records must be 722 bytes in length, contain readable ASCII characters in the correct field positions with correct format and fill characters. See appendices for a complete list of required fields by encounter type.

3.2 Header Record

The **Header Record** is the first record in the file and is critical to the loading process. It contains key information about who is submitting, how many records are in the file, etc.

Header Record Fields and Layout

Field #	Field Name	Position		Size	Format, Justify, Fill **
		Start	End		
901	HMO ID	1	8	8	NUM
902	Submission Date	9	16	8	MMDDYYYY
903	Beginning Process Date	17	24	8	MMDDYYYY
904	Ending Process Date	25	32	8	MMDDYYYY
905	Number of Records Transmitted	33	40	8	NUM RJ ZF
906	HMO Contract Administrator Last Name	41	75	35	A/N LJ BF
907	HMO Contract Administrator First Name	76	100	25	A/N LJ BF
908	HMO Contract Administrator Email	101	150	50	A/N LJ BF
909	HMO Technical Contact #1 Last Name	151	185	35	A/N LJ BF
910	HMO Technical Contact #1 First Name	186	210	25	A/N LJ BF
911	HMO Technical Contact #1 Email	211	260	50	A/N LJ BF
912	HMO Technical Contact #2 Last Name	261	295	35	A/N LJ BF
913	HMO Technical Contact #2 First Name	296	320	25	A/N LJ BF
914	HMO Technical Contact #2 Email	321	370	50	A/N LJ BF
915	HMO Technical Contact #3 Last Name	371	405	35	A/N LJ BF
916	HMO Technical Contact #3 First Name	406	430	25	A/N LJ BF
917	HMO Technical Contact #3 Email	431	480	50	A/N LJ BF
918	Filler	481	722	241	Blanks

Format Definitions
A/N = alphanumeric (uppercase A – Z, 0 – 9)
NUM = numeric (0 – 9)
LJ = the value is left justified
RJ = the value is right justified

BF = the value is blank filled
ZF = the value is zero filled.
MMDDYYYY (date) the elements include any leading zero.

**** If BF or ZF are not specified, then the value must be the exact number of characters.**

3.3 Detail Record

The detail records are the records following the header record and contain the actual encounter data (i.e. billing provider, encounter type, member name and number, diagnosis codes etc.). They are loaded immediately after a successful loading of the header record.

Detail Record Fields and Layout

Field #	Field Name	Position		Size	Format, Justify, Fill **
		Start	End		
1	Encounter Type	1	1	1	A/N
2	HMO ID	2	9	8	NUM
3	Data Source	10	10	1	NUM
4	Record Type	11	11	1	A/N
5	Record Identification Number	12	41	30	A/N LJ BF
6	Process Date	42	49	8	MMDDYYYY
7	Billing Provider NPI	50	59	10	NUM LJ BF
8	Billing Provider Name	60	94	35	A/N LJ BF
90	Billing Provider Taxonomy	95	104	10	A/N LJ BF
91	Billing Provider ZIP+4	105	113	9	NUM LJ BF
9	Member ID	114	123	10	NUM LJ BF
10	Member Last Name	124	158	35	A/N LJ BF
11	Member First Name	159	183	25	A/N LJ BF
12	Member Middle Initial	184	184	1	A/N LJ BF
13	Other Provider	185	219	35	A/N LJ BF
14	Attending Physician	220	254	35	A/N LJ BF
15	Referring Provider NPI	255	264	10	NUM LJ BF
16	Facility Name or Number	265	299	35	A/N LJ BF
17	Principal Diagnosis Code	300	307	8	A/N LJ BF
18	Diagnosis Code #2	308	315	8	A/N LJ BF
19	Diagnosis Code #3	316	323	8	A/N LJ BF
20	Diagnosis Code #4	324	331	8	A/N LJ BF
21	Diagnosis Code #5	332	339	8	A/N LJ BF
22	Diagnosis Code #6	340	347	8	A/N LJ BF
23	Diagnosis Code #7	348	355	8	A/N LJ BF
24	Diagnosis Code #8	356	363	8	A/N LJ BF
25	Diagnosis Code #9	364	371	8	A/N LJ BF
94	Diagnosis Code #10	372	379	8	A/N LJ BF
95	Diagnosis Code #11	380	387	8	A/N LJ BF

Field #	Field Name	Position		Size	Format, Justify, Fill **
		Start	End		
96	Diagnosis Code #12	388	395	8	A/N LJ BF
97	Diagnosis Code #13	396	403	8	A/N LJ BF
98	Diagnosis Code #14	404	411	8	A/N LJ BF
99	Diagnosis Code #15	412	419	8	A/N LJ BF
100	Diagnosis Code #16	420	427	8	A/N LJ BF
101	Diagnosis Code #17	428	435	8	A/N LJ BF
102	Diagnosis Code #18	436	443	8	A/N LJ BF
103	DX Version Indicator	444	444	1	A/N LJ BF
26	Admission Diagnosis Code	445	452	8	A/N LJ BF
	[Removed DRG Code]				
28	ICD Procedure Code #1	453	457	5	A/N LJ BF
29	ICD Procedure Code #2	458	462	5	A/N LJ BF
30	ICD Procedure Code #3	463	467	5	A/N LJ BF
31	ICD Procedure Code #4	468	472	5	A/N LJ BF
32	ICD Procedure Code #5	473	477	5	A/N LJ BF
33	ICD Procedure Code #6	478	482	5	A/N LJ BF
34	Admission Type	483	483	1	NUM
35	Admission Source	484	484	1	A/N
36	Patient Status Code	485	486	2	NUM RJ ZF
37	Admission Date	487	494	8	MMDDYYYY
38	Value Code #1	495	496	2	A/N RJ ZF
39	Value Amount #1	497	503	7.2	NUM RJ BF
40	Value Code #2	504	505	2	A/N RJ ZF
41	Value Amount #2	506	512	7.2	NUM RJ BF
42	Value Code #3	513	514	2	A/N RJ ZF
43	Value Amount #3	515	521	7.2	NUM RJ BF
44	Value Code #4	522	523	2	A/N RJ ZF
45	Value Amount #4	524	530	7.2	NUM RJ BF
58	From Date of Service	531	538	8	MMDDYYYY
59	To Date of Service	539	546	8	MMDDYYYY
60	Prescription Date	547	554	8	MMDDYYYY
61	Fill Date	555	562	8	MMDDYYYY
62	National Place of Service	563	564	2	NUM RJ
64	Procedure Code	565	569	5	A/N LF BF
65	Modifier Code #1	570	571	2	A/N
66	Modifier Code #2	572	573	2	A/N

Field #	Field Name	Position		Size	Format, Justify, Fill **
		Start	End		
87	Modifier Code #3	574	575	2	A/N
88	Modifier Code #4	576	577	2	A/N
67	Revenue Code	578	581	4	NUM RJ ZF
68	NDC Code	582	592	11	A/N
69	Quantity	593	601	9.3	NUM RJ ZF
70	Days Supply	602	604	3	NUM RJ ZF
71	Performing Provider NPI	605	614	10	NUM
72	Performing Provider Name	615	649	35	A/N LF BF
92	Performing Provider Taxonomy	650	659	10	A/N
93	Performing Provider ZIP+4	660	668	9	NUM
73	Prescriber DEA	669	678	10	A/N
74	Prescription Number	679	686	8	A/N LF BF
75	Refill Indicator	687	688	2	NUM RJ ZF
76	Unit Dose	689	689	1	NUM
77	DAW (Dispense as written)	690	690	1	NUM
78	Emergency Service Indicator	691	691	1	A/N
79	HealthCheck Referral Indicator	692	692	1	A/N
80	Family Planning Indicator	693	693	1	A/N
89	Financial Indicator	694	694	1	A/N
81	Charges	695	703	9.2	NUM RJ ZF
82	TPL Paid Amount	704	710	7.2	NUM RJ ZF
83	ANSI/NCPDP Code #1	711	713	3	A/N LJ BF
84	ANSI/NCPDP Code #2	714	716	3	A/N LF BF
85	ANSI/NCPDP Code #3	717	719	3	A/N LJ BF
86	ANSI/NCPDP Code #4	720	722	3	A/N LJ BF

Format Definitions

A/N = alphanumeric (uppercase A – Z, 0 – 9)
NUM = numeric (0 – 9)
LJ = the value is left justified
RJ = the value is right justified
BF = the value is blank filled
ZF = the value is zero filled. Note that if a value is not available for a field and is not required, the entire field should be left blank, not filled with all zeros.
MMDDYYYY (date) the elements include any leading zero

**** If BF or ZF are not specified, then the value must be the exact number of characters.**

3.4 Encounter Types

The term **"encounter record"** refers to a series of data elements stored in a record format representing an encounter between a ForwardHealth member and their healthcare provider. An encounter record may be prepared from a single detail line from a claim such as the 1500 HEALTH INSURANCE CLAIM FORM, UB-04, or medical chart. (See the section called "Building an Encounter from Medical Records/Chart Review" for details.) The encounter record may also be created from information gathered from a medical record or from information provided from an outside source, such as a county health department.

Each encounter record must be identified as one of the following encounter types:
(D)=Dental, (I)=Inpatient, (O)=Outpatient, (M)= Medical, (P)=Pharmacy

The encounter type distinguishes which fields are required on the detail record. Following is a list of encounter types with descriptions:

Encounter Types

Encounter Type	Code	Category description	
Dental	D	All dental visits	
Inpatient	I	Inpatient hospitalization encounters	
		Nursing homes	
Outpatient	O	Outpatient encounters	
		Day surgery	
		ER visits	
		Home health	
Medical	M	Home health	Hospice
		Oral surgery	Transportation
		DME (HCPCS Codes)	Other medical
		Health check	Office visits
		Outpatient	Ambulatory services
		Day Surgery	Therapy services
		Mental health	DMS using HCPCS
		ER visits	
** Pharmacy	P	All encounters with NDC codes	
		Disposable Medical Supplies (DMS) using NDCs	

**** Pharmacy Encounter Types with a fill date on or after 2/1/2008 will no longer be processed through the Encounter System.**

See encounter type matrix on the next page for a more detailed list.

3.5 Encounter Type Matrix

Encounters may be classified into more than one encounter type group. The classification may be based on the type of claim form used by the provider to report the encounter. Prior to determining which encounter type to use, it may be helpful to study the table in the appendices called "Required Fields Based on Encounter Type". Below is a matrix referencing when encounters can be submitted under multiple encounter types. This may also be helpful when determining which encounter type is appropriate.

Selecting Encounter Types

Description	Encounter Types				
	Dental	Inpatient	Outpatient	Medical	Pharmacy
Dental	D				
Oral Surgery				M	
** Pharmacy Drugs and Services					P
Disposable Medical Supplies (DMS)				M*	P*
Inpatient Hospitalizations		I			
Nursing Home Visits		I			
Outpatient Surgery or Day Surgery			O*	M*	
Outpatient Hospital			O*	M*	
ER Visits			O*	M*	
Home Health			O*	M*	
Hospice				M	
Transportation				M	
Durable Medical Equipment (DME)				M*	P*
Health Check				M	
Ambulatory Services or Surgery				M	
Office Visits				M	
Ambulatory Mental Health				M	
Therapy Services (i.e. PT, OT,ST)				M	

* Some encounters may be classified in multiple encounter types. The classification may be based on the type of claim form used by the provider to report the encounter. For example, some organizations may bill a service on a UB-04 while others may use a 1500 HEALTH INSURANCE CLAIM FORM or a Pharmacy vs. a 1500 HEALTH INSURANCE CLAIM FORM, etc.

**** Pharmacy Encounter Types with a fill date on or after 2/1/2008 will no longer be processed through the Encounter System.**

3.6 Record Types

There are two types of encounter detail records. These two record types are key in identifying the purpose of data contained within the record. Following are the definitions of these two types:

Record Types

Original record	**'O'**	An original record is defined as a record submitted for the first time. The majority of records submitted will be originals.
Reversal record	**'R'**	A reversal record is defined as a record that negates or reverses an original record. Reversal records are most generally used for correcting previously sent original records after the HMO has adjusted the encounter due to internal or provider changes to that encounter.

3.7 Building an Encounter from Medical Records/Chart Review

An encounter record may be created from data acquired through medical record/chart reviews. These encounter records may be built for services provided for which no claim was received, but for which the HMO wishes to supplement its encounter data set. Examples of services or items the HMO might include are:
HealthCheck services
Lead screening and testing
Immunizations

The following table identifies the fields required when building an encounter record from medical record/chart review including the field number, name and description. The field number represents where you will find the field in the detail record layout (see the detail record layout in the appendices). If additional information is available, please include that data as well. These limited field requirements are only allowed on records built from medical record/chart reviews. The layout of this record must be identical to the layout used for all other types of encounters; space/zero fill where appropriate to achieve a 586-byte record.

Required Fields for Medical Record/Chart Reviews

Field No.	Field Name	Description
1	Encounter Type	Identifies what type of encounter.
2	HMO ID	HMO ForwardHealth ID
3	Data Source	Data Source 2-record prepared from data supplied by medical record review. Data Source 3-record prepared from data from another provider (Public Health Agency) that did not result in a claim.
4	Record Type	Record type "Original" for submission.
5	RIN	Assigned record number after building encounter.
6	Process Date	The date the encounter was processed by the HMO.
7	Performing Provider NPI	The National Provider ID of the provider that performed services rendered (for any non-medical providers without an NPI, the ForwardHealth ID may be used).
92	Performing Provider Taxonomy	The taxonomy code for the performing provider

Field No.	Field Name	Description
93	Performing Provider ZIP+4	The nine digit ZIP code of the performing provider.
9	Member ID	ForwardHealth member ID number.
10	Member Last Name	ForwardHealth member last name.
11	Member First Name	ForwardHealth member first name.
16	Facility or Provider Name	The name of facility where services were rendered (i.e. Public Health Clinic or the name of the provider). Must have either the billing provider name or the facility name.
17	Diagnosis Code #1	Principal diagnosis code relating to care.
58	From Date of Service	The date of the encounter.
64	Procedure Code	CPT or HCPCS code.
69	Quantity	Quantity of services rendered.

4 Special Billing Situations

There are a wide range of acceptable practices. Many of these practices come directly from the fee-for-service environments of Medicare, Medicaid and commercial plans. A fundamental difference between encounter records and claims records is the ultimate use of the record. In the fee-for-service environment, the record is normally a request for payment. In the encounter environment, the record is notification that an interaction between a healthcare provider and member occurred. However, it is important to note that encounter data is used for financial analysis. Accuracy in reporting encounters may affect future decisions regarding managed care capitation rates and reimbursements.

4.1 Single Detail Showing Dates of Service

The following graphic is a "mock-up" of a record/claim submitted by a provider. It indicates 5 services were rendered to John Smith between June 1st. and June 29th.

Wisconsin Speech TherapyAssociates
Somewhere, Wi 50000

Patient name	From date of service	To date of service	Procedure code	Provider ID	Quantity
John Smith	06/01/2000	06/29/2000	92507	39000000	5

The following examples show the acceptable and the unacceptable way of submitting this information.

4.1.1 Acceptable

This graphic shows the HMO has submitted 5 records, 1 record for each event. Each record had a unique Record Identification Number (RIN) and unique dates of services.

RIN	Record Type	Encounter Type	Medicaid ID	Billing Provider ID	Procedure Code	From Date	To Date	Quantity
RIN1A	O	O	3303333000	39000000	92507	06/01/2000	06/01/2000	1
RIN1B	O	O	3303333000	39000000	92507	06/08/2000	06/08/2000	1
RIN1C	O	O	3303333000	39000000	92507	06/15/2000	06/15/2000	1
RIN1D	O	O	3303333000	39000000	92507	06/22/2000	06/22/2000	1
RIN1E	O	O	3303333000	39000000	92507	06/29/2000	06/29/2000	1

4.1.2 Unacceptable

This graphic shows the HMO has submitted 1 record reporting 5 events. It is impossible to determine the date of service for each event. Records submitted in this manner will only be considered as two days of service – one in the FDOS and one in the TDOS.

RIN	Record Type	Encounter Type	Medicaid ID	Billing Provider ID	Procedure Code	From Date	To Date	Quantity
RIN1	O	O	3303333000	39000000	92507	06/01/2000	06/29/2000	5

4.2 Inpatient Encounters

There are two acceptable methods for creating Inpatient encounters for hospital and nursing home stays. The first method allows for a single Inpatient encounter record for the entire inpatient stay. This record corresponds to the information in the header/footer sections of the UB04 claim form, with summary information aggregated from the detail lines. The single record must have a hospitalization accommodation revenue code (0100-0179 or 0200-0219), the Charges field must contain all the charges for the entire stay, and all applicable diagnosis and procedure codes must be included. This is necessary for appropriately selecting the inpatient encounter record for MSDRG costing.

The second method (preferred by DHCAA) provides multiple Inpatient encounter records for each stay, as required to describe services rendered in detail. These records normally correspond to the detail lines on the UB04 claim form. The records must be coded consistently to provide the capability to group all the related Inpatient records into one hospital stay for utilization and costing purposes. Each stay must include at least one encounter with a hospitalization accommodation revenue code necessary for selecting the inpatient encounters for MSDRG costing. The total of all the Charge fields on all encounters for the stay (except any record with '0001' revenue code, which will be ignored) should equal the total claim amount(s) on the UB04 claim form(s). Two situations requiring multiple encounter records per stay are described in the following sections.

4.2.1 Typical, Limited Hospitalization

The requirements for coding inpatient encounters vary slightly, depending upon the situation. Most often, encounters report the typical, limited stay hospitalization which is created in total from one UB04 claim. All encounters for this type of stay must have the same Admission Date, Billing Provider NPI, Member ID, FDOS, TDOS, Diagnosis Codes, and ICD Procedure Codes. The Patient Status Code should indicate the status at the time the patient left the hospital (01-08, 20, 41, 61, 71, or 72).

Field No.	Field Name	Requirement
1	Encounter Type	"I" - Inpatient
7	Billing Provider NPI	All records for the stay must use the same NPI.
90	Billing Provider Taxonomy	All records for the stay must use the same billing provider taxonomy.
91	Billing Provider ZIP+4	All records for the stay must use the same Billing Provider ZIP+4.
9	Member ID	All records for the stay must be for the same member.
17	Principle Diagnosis Code	All records for the stay must have the same Principal Diagnosis.
18-25 and 94-103	Diagnosis Code #2 through Diagnosis Code #18	All records for the stay must have the same Diagnosis Codes.

Field No.	Field Name	Requirement
103	DX Version Indicator	All records must indicate the ICD version being utilized.
28-33	ICD Procedure Codes	All records for the stay must have the same ICD Procedure Codes.
36	Patient Status Code	The stay will not be considered completed until a record is submitted with a discharge Patient Status Code (01-08, 20, 41, 61, 71, or 72).
37	Admission Date	All records for the stay must have the same Admission Date.
58	From Date of Service	The beginning service date on the UB-04. Cannot be earlier than Admission Date.
59	To Date of Service	The ending service date on the UB-04. The encounter(s) with a discharge Patient Status Code must have the discharge date in the To Date of Service.
64	Procedure Code (CPT/HCPCS)	Optional, as used by the HMO. Can vary between encounters for the stay.
67	Revenue Code	At least one inpatient encounter record for the stay must contain a revenue code in the accommodation range (0100–0199 or 0200-0219).
81	Charge	The billed charges for the services described by the revenue code. The sum of all Charge fields for all encounters for the stay (except records with revenue code '0001') must be the total claim amount from the UB-04.

Example of a Correct Inpatient Encounter Encoding – Typical

This example shows a member was admitted on January 16.

- RIN 111 includes codes and charges for accommodations (Revenue code 0122 – OB/2Bed).
- RIN 112 shows the patient had an ultrasound (Revenue code 0402).
- RIN 113 indicates laboratory charges.
- RIN 114 is a summary record for the hospitalization (code 0001), and contains the sum of all charge fields from all the other detail impatient encounters for this stay. This record is optional, and normally not included.

RIN	Member ID	Principal Diagnosis Code	Admission Date	FDOS	TDOS	Patient Status Code	Patient Status Desc	Billing Prov ID	Billing Prov Taxonomy	Billing prov Zip + 4	Revenue Code	Charge
111	1233333333	64663	1/16/02	1/16/02	1/18/02	01	Discharged to home or self care (routine discharge).	1020304050	208M00000X	543219876	0122	852.00
112	1233333333	64663	1/16/02	1/16/02	1/18/02	01	Discharged to home or self care (routine discharge).	1020304050	208M00000X	543219876	0402	530.00
113	1233333333	64663	1/16/02	1/16/02	1/18/02	01	Discharged to home or self care (routine discharge).	1020304050	208M00000X	543219876	0300	420.00
114	1233333333	64663	1/16/02	1/16/02	1/18/02	01	Discharged to home or self care (routine discharge).	1020304050	208M00000X	543219876	0001	1802.00

4.2.2 Interim Billing Hospitalization and Nursing Home Stays

Some institutions may submit multiple UB-04 claim forms for one member stay. This usually results when the stay extends beyond a typical billing period (e.g., a month) for extended hospitalizations and nursing home stays. Inpatient encounters for partial stays (still a patient) should be reported when the interim UB-04 form is received. The entire stay might be reported through multiple submissions in consecutive months until the patient is discharged.

When inpatient encounters for one stay are constructed from multiple claim forms, some variation is allowed. Admission Dates, Billing Provider NPIs, and Member IDs must still remain the same for all encounters for the stay. Diagnosis and ICD Procedure Codes may change between claim forms, but should remain consistent. That is, a subsequent claim form may specify a different Principal Diagnosis Code than the previous form for the same stay. The previous Diagnosis Code #1 must be carried on the encounters for the later claim form(s) as a Diagnosis Code #2-18. The same applies for ICD Procedure Codes.

The final claim form and the resulting inpatient encounters must have a discharge Patient Status Code and all applicable diagnosis and procedure codes for the entire stay.

Field No.	Field Name	Requirement
1	Encounter Type	"I" - Inpatient
7	Billing Provider NPI	All records for the stay must use the same NPI
90	Billing Provider Taxonomy	All records for the stay must use the same billing provider taxonomy.
91	Billing Provider ZIP+4	All records for the stay must use the same Billing Provider ZIP Code+4.
9	Member ID	All records for the stay must be for the same member.
17-25: 94-103	Principle Diagnosis Code through Diagnosis Code #18	All encounter records from one claim form must have the same diagnoses. Additional diagnosis codes from additional claim forms can be added to later records, but should include all applicable previous codes.
103	DX Version Indicator	All records must indicate the ICD version being utilized.
28-33	ICD Procedure Codes	All encounter records from one claim form must have the same ICD Procedure Codes. Additional ICD procedure codes from additional claim forms can be added to later records, but should include all applicable previous codes.
36	Patient Status Code	The stay will not be considered completed until a record is submitted with a discharge Patient Status Code (1-08, 20, 41, 61, 71, or 72).
37	Admission Date	All records for the entire hospital stay must have the same Admission Date.
58	From Date of Service	The beginning service date on the UB-04. Cannot be earlier than Admission Date.
59	To Date of Service	The ending service date on the UB-04. The encounter(s) with a discharge Patient Status Code must have the discharge date in the To Date of Service.

Field No.	Field Name	Requirement
64	Procedure Code	Optional, as needed. Can vary between encounters for the stay.
67	Revenue Code	At least one inpatient encounter record for the stay must contain a revenue code in the accommodation range (0100–0199 or 0200-0219).
81	Charge	The billed charges for the services described by the revenue code. The sum of all Charge fields for all encounters for the stay (except records with revenue code '0001') must equal the total of the claim amounts from all claim forms.

Example of the Correct Method for Inpatient Extended Stay (Interim Billing)

This is an example of a premature newborn stay (identified by Principal Diagnosis Code of 76510) of 51 days spanning 3 hospital billing periods.

- The provider has submitted two interim bills for March and April (encounters with a Patient Status of 30) and a final discharge bill for May (Patient Status of 06). These will be interpreted as three separate groups of encounter records, but one inpatient Stay.
- The Admission Date remains the same for the entire stay.
- Each set of inpatient records for a billing cycle should have the same diagnosis and procedure codes. In this example, the Principal ICD Procedure Code changed during the second billing period (April) to 301. The original Principal ICD Procedure is then carried on subsequent encounters as an Other ICD Procedure Codes. The final billing for May contains all relevant procedures for the entire stay.
- From and To Dates of Service reflect consecutive admission, billing periods, and discharge, while the common Admission Date ties the entire stay together.
- Three accommodation revenue codes were reported, one for each billing cycle (RINs 101, 201, and 303).

RIN	Member ID	Admission Date	Admit Diag Code	FDOS	TDOS	Prin Diag Code	Other Diag Codes	Patient Status Code	Prin ICD Proc Code	Other ICD Proc Codes	Revenue Code/ Desc	Charge
(March billing cycle)												
101	4433333333	3/17/02	76510	3/17/02	3/31/02	76510		30	**311**		0203 ICU PEDS	15000.00
102	4433333333	3/17/02	76510	3/17/02	3/31/02	76510		30	**311**		0258 IV SOL	101.00
103	4433333333	3/17/02	76510	3/17/02	3/31/02	76510		30	**311**		0370 ANESTHESIA	5000.00
104	4433333333	3/17/02	76510	3/17/02	3/31/02	76510		30	**311**		0410 RESP SVC	2500.00
105	4433333333	3/17/02	76510	3/17/02	3/31/02	76510		30	**311**		0230 NURSING	5000.00
106	4433333333	3/17/02	76510	3/17/02	3/31/02	76510		30	**311**		0301 LAB/CHEM	101.00
(April billing cycle)												
201	4433333333	3/17/02	76510	4/1/02	4/30/02	76510		30	301	**311**	0123 PEDS	6000.00
202	4433333333	3/17/02	76510	4/1/02	4/30/02	76510		30	301	**311**	0470 AUDIOLOGY	250.00
203	4433333333	3/17/02	76510	4/1/02	4/30/02	76510		30	301	**311**	0230 PHARMACY	150.00
(May billing cycle)												
301	4433333333	3/17/02	76510	5/1/02	5/6/02	76510		06	301	**311**	0420 PHY THER	1200.00
302	4433333333	3/17/02	76510	5/1/02	5/6/02	76510		06	301	**311**	0230 NURSING	1000.00
303	4433333333	3/17/02	76510	5/1/02	5/6/02	76510		06	301	**311**	0123 PEDS	1200.00

5 American National Standard Institute (ANSI) Codes

ANSI codes are a nationally recognized set of values that describe the final disposition of a claim/encounter. In many organizations, these types of codes are generally referred to as Explanation of Benefit (EOB) codes or Claim Adjustment Reason Codes. The primary purpose of these codes is to describe the action taken by the healthcare payer. Such action includes:

- Approving
- Denying
- Reduction or adjustment to the payment
- Informational

A secondary purpose of the codes is to provide the reasons behind the actions. Examples include but are not limited to:

- Patient not covered at time services were provided
- Duplicate claim
- Charges are covered under a capitation agreement

5.1 State Objectives

One of the objectives of the DHCAA is to collect data that mirrors the information about all services provided to ForwardHealth members that might reside in the HMO's processing system. The purpose of this objective is to enable the DHCAA to accurately interpret all interactions between the member and healthcare provider, including those that may have resulted denied claims/encounters. ANSI codes help create this clear image of the encounter record, and are critical to the process of gathering complete, accurate data on the record. Due to this State objective, all internal explanation codes must be mapped to ANSI codes. The exception to this is on Pharmacy encounters. See the NCPDP section for details on use of reject codes for pharmacy.

Issue:

The DHCAA has realistic expectations about correcting errors. They recognize that some errors cannot be fixed and by the very nature of the error, the HMO may be resubmitting another record anyway. ANSI codes 1 through 4 are data elements which are classified as "required, if applicable" and are open to interpretation. As a result, the following inconsistencies have been noted:

- **Use of the complete ANSI code set:**
  Some HMOs use a number of the codes, while others only use a select few.
- **Using the same ANSI code to define different types of event:**
  Due to the non-specific nature of these codes, use of the same code for multiple reasons is likely.
- **No hierarchy in the ANSI code set:**
  Some HMOs stop with one ANSI code and do not have a hierarchy in place to display multiple ANSI codes; there is no consistent priority established when reporting ANSI codes.

Solution:

Due to the above-mentioned inconsistencies, usage patterns of ANSI codes were studied. The outcome of this study aided the DHCAA in understanding how HMOs use the codes. It also helped in making a determination when an erred record with an ANSI code requires correction by the HMO and when the code exempts the HMO from making corrections. All records regardless of the presence of an ANSI code are edited. After editing is complete, the ANSI code(s) determines whether or not the record is placed in the accepted record table or erred record table. Specifics about the reporting of accepted/erred records with ANSI codes can be found in the Submission and Status Report (SSR) section of this guide.

A great deal of thought and research has gone into determining which ANSI codes require error correction and which ones do not require correction. However, if the HMO detects a pattern of consistently denying certain claims from their network providers which cannot be corrected but EDS also reports the corresponding encounter as a critical error, then the HMO should contact EDS to discuss alternative ANSI codes.

5.2 ANSI Code Updates and Procedures

Due to possible additions/deletions of ANSI codes, DHCAA and EDS will update the table of valid ANSI codes quarterly. Codes may be changed to either require correction or not require correction as more data becomes available for review and/or HMOs provide feedback on how ANSI codes are utilized in their system. **See Appendix G for a list of ANSI codes and their categorization of "Correction Required" or "No correction Required".**

6 National Council for Prescription Drug Programs (NCPDP)

NCPDP is an ANSI-accredited standards development organization. The NCPDP Reject Codes that have been established by this organization are a nationally recognized set of values that describe the final disposition of a claim. In many organizations these type of codes are often referred to as Explanation of Benefit (EOB) codes. The primary purpose of these codes is to describe the action taken by the healthcare payer.

Note: The information in this section applies to encounters with a fill date prior to 2/1/08

6.1 State Objectives

One of the objectives of DHCAA is to collect data that mirrors the information about all services provided to ForwardHealth members that might reside in the HMO's processing system. The purpose of this objective is to enable DHCAA to accurately interpret all interactions between the member and healthcare provider, including those that may have resulted in denied claims/encounters. NCPDP reject codes help create this clear image of the pharmacy encounter record, and are critical to the process of gathering complete, accurate data on the record.

Issue

An objective of the encounter data collection process is to provide a complete image of health care services rendered to all ForwardHealth members.

An issue that has clouded the process from the inception is the concept of ***denied***. There is a wide variance in the definition of *denied*, as well as how the definition is applied. For these reasons, the decision was made to include denied records in the dataset. Our experience with 4 types of encounters: dental, inpatient, outpatient, and medical is the basis of our reasoning to include denied records in the dataset. The same reasoning may not be applicable for pharmacy encounters. It is not a situation of not wanting denied pharmacy encounters; rather there are very few denied pharmacy encounters.

We have spoken with HMOs about their use of NCPDP denial codes on pharmacy encounters. In the course of these conversations, several HMOs have made the remark, "We don't get denied encounters from our PBM." Our initial response was, "Why not?" The more we thought through the process, the reason became apparent.

HMOs use the services of pharmacy benefit management (PBM) companies. The nature of the relationship between the HMOs and the PBMs vary. Two aspects of this relationship are constant, the PBM acts as a mini claim processing organization and the HMO supplies the PBM with a list of eligible members.

The opportunity for denied encounters are the product of 1) the ability of a pharmacy to check eligibility at the time the prescription is filled and 2) the percentage of claims that are processed electronically. In instances where the pharmacy has the capability to check eligibility prior to filling the prescription and file the claim electronically, the opportunity for a denial is quite rare, if not totally impossible. It is only in those instances where real time authorization is unavailable that the opportunity for denied encounters becomes realistic.

Even in organizations where all eligibility and authorizations are checked electronically, some prescriptions are filled that should have been rejected. In rare instances, prescriptions that should have been rejected are filled due to electronic communications breakdowns. The pharmacy is unable to check eligibility and receive authorization, but in an act of good faith, fills the prescription. The claim may be rejected after the fact.

On a regular basis, the PBM provides a file of activities to the HMO. The file documents every prescription that was dispensed with PBM authorization. It will only be instances where pharmacies are allowed to fill prescriptions without first checking authorization that eligibility-related denials take place. Non-electronic claim submissions also open the possibility of denials due to administrative and policy requirements.

Solution

NCPDP Reject Codes will be the accepted standard on pharmacy encounters. All other encounter types (dental, inpatient, outpatient, medical) will use ANSI codes. After reviewing the NCPDP code descriptions, a decision was made to accept pharmacy records containing an NCPDP reject code, regardless of edit failures. This decision was made by DHCAA due to the denied nature of these codes. An important difference between NCPDP and ANSI reject codes is that all NCPDP reject codes fall into the "No correction required" category whereas records with ANSI codes may or may not require correction depending on the code.

6.2 NCPDP Code Updates and Procedures

Due to possible additions/deletions of NCPDP codes, DHCAA and EDS will update the table of valid NCPDP codes as needed. **See Appendix H for a current list of NCPDP codes.**

7 Submission Schedule

7.1 Overview

HMOs must provide encounter data information on a monthly basis. The process goes as follows: an HMO will provide monthly submissions.

7.1.1 Monthly Submission Events

S1. **Submission Period**
Submissions will be accepted throughout the entire month.

S2. **Submission Processing**
The time period when EDS processes the data file

S3. **Submission Status Report Production**
The time period when EDS returns the SSRs to the HMOs

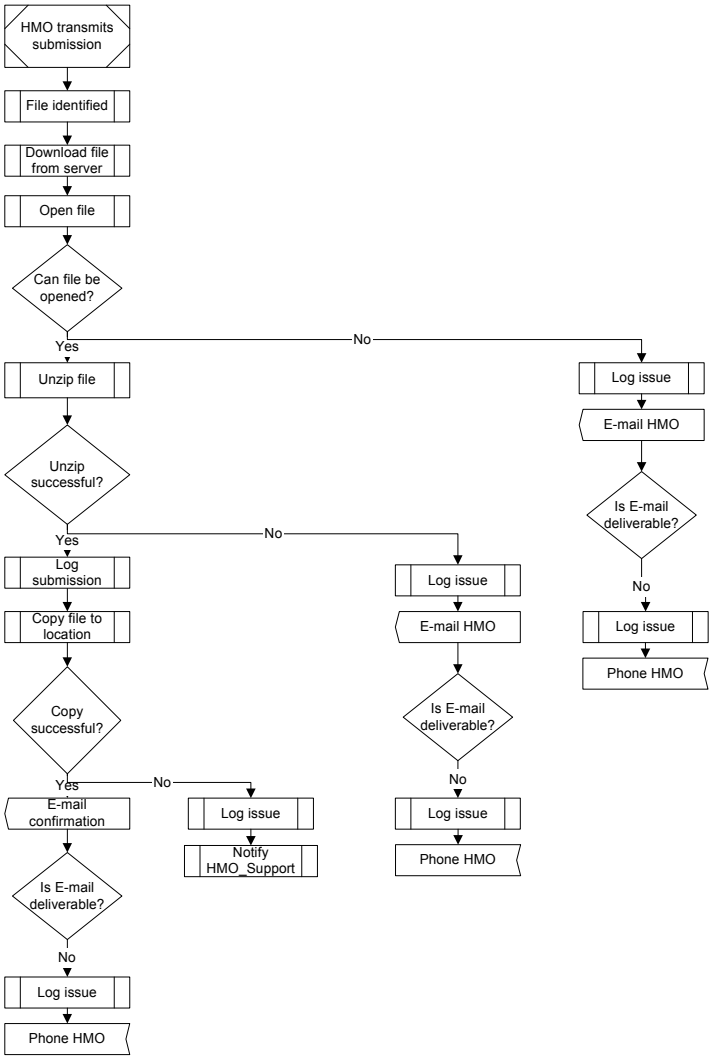
S4. **State Summary Reports**
The day when EDS produces monthly summary report for state

8 Transmission Method

The transmission method required by DHCAA is SFTP – Secure File Transfer Protocol. Security requirements are presented in the Data Security section of this document.

8.1 SFTP

Please see Appendix D for instructions and requirements for using this form of data transmission.



9 Data Security

9.1 Overview

The security of each transmission is of utmost importance to DHCAA and EDS. The goal of DHCAA and EDS is to fully protect the member's rights to confidentiality. HMOs will be notified as technology advances, security measures improve and new pieces of security software become available. Non-compliance with established security measures will be addressed.

9.2 Compression

HMOs must compress their files using a standard zip program (i.e. WINZIP, PKZIP). Compression decreases the size of the file to reduce transmission time, and helps protect its integrity.

10 File Naming Conventions

Standardized naming conventions have been established to distinguish encounter data production submissions from test submissions, to identify the time period, track encounter data submissions, and automate the loading process. This convention must be used regardless of the media.

Please refer to Appendix C for a description and examples of the naming conventions for submission zip files.

11 Submission Loading

11.1 Overview

The encounter data file contains ForwardHealth member encounter records. The file is made up of two types of records each 722 bytes in length. Every file must contain one header record, which contains summary information about the submission (i.e. date of submission, number of records transmitted, technical contact names and email addresses, etc.). The balance of the submission contains detail records that provide detailed information about each encounter (i.e. billing provider, member, diagnosis, procedure, encounter type etc.).

Following is a detailed description of the submission loading requirements for both header and detail records. It should be noted that the loading submission process established for the header record automates communication with the HMO, EDS, and DHCAA. Accurate Contract Administrator and Technical Contact information is essential to keep communication lines open with appropriate personnel.

11.2 Processes

Of the many processes associated with a submission, two impact the loading of the file. The first process deals with header record loading. The second process deals with detail record loading. When loading a file, a series of header and detail loading checks occur.

11.3 Header Record Loading

The header record is the first record in the file and is critical to the loading process. The record goes through a series of system checks for length and valid ASCII characters. Once that process is completed, the record is parsed and loaded. The process then checks for the presence of required fields. Another series of checks compares dates and date ranges. If a required field fails a check, the loading process ceases and the entire submission is rejected. The HMO must correct all errors and resubmit. The HMO and the HMO Support Group are notified via email of the failure.

Header Record Loading

Number	Action	Result	Log Entry	Additional action
1	**Decompressed file is ready to load**		No	Continue process
2	**Select first record in the submission. Record must be 722 bytes in length.**	Record is 722 bytes in length	No	Continue process
		Record does not contain 722 bytes, do not load the record. Submission is rejected.	Yes	Transmit e-mail to HMO stating submission failed to load due to a header record error
				Loading process stopped
3	**Check record for non-ASCII characters**	All characters ASCII, load record into table.	No	Continue process
		If non-ASCII characters present, do not load record. Submission is rejected.	Yes	Transmit e-mail to HMO stating submission failed to load due to a header record error
				Loading process stopped
4	**Check for valid HMO ID**	HMO ID is valid	No	Continue process
		HMO ID is missing/invalid	Yes	Transmit e-mail to HMO stating submission failed due to a header record error
				Loading process stopped

Header Record Loading

Number	Action	Result	Log Entry	Additional action
5	**Check that there are at least 2 records in the submission, 1 header and at least 1 detail**	There is more than 1 record	No	Continue process
		There is only a header record with no detail records	Yes	Transmit e-mail to HMO stating submission failed due to a header record error
				Loading process stopped
6	**Compare file name to HMO ID in record**	The file name and HMO ID match	No	Continue process
		The file name and HMO ID do not match	Yes	Transmit e-mail to HMO stating submission failed to load due to a header record error
				Loading process stopped
7	**Compare Submission Date to EDS' loading date**	Submission date is on or before EDS loading date	No	Continue process
		Submission date is after EDS loading date	Yes	Transmit e-mail to HMO stating submission failed due to a header record error
				Loading process stopped
8	**Check for valid submission date**	Valid submission date	No	Continue process
		Invalid submission date checks include: ➢ Prior to 01012000 ➢ Invalid date/format ➢ Greater than date received at EDS	Yes	Transmit e-mail to HMO stating submission failed to load due to a header record error
				Loading process stopped
9	**Check for valid beginning process date**	Valid beginning process date	No	Continue process
		Invalid beginning process date checks include: ➢ Prior to 01012000 ➢ Invalid date/format ➢ After Submission Date ➢ Greater than 'Ending process date' ➢ Prior to 'Ending process date' of previous submission	Yes	Transmit e-mail to HMO stating submission failed to load due to a header record error
				Loading process stopped

10	**Check for valid ending process date**	Valid ending process date	No	Continue process
		Invalid ending process date ➢ Invalid date/format ➢ Prior to beginning date of submission ➢ After Submission Date ➢ Prior to 'Ending proc. date of previous sub.	Yes	Transmit e-mail to HMO stating submission failed to load due to a header record error
11	**Check for Contract Administrator Last name**	Name present	No	Continue process
		Name absent	No	Use contact last name from previous header record.
12	**Check for Contract Administrator First name**	Name present	No	Continue process
		Name absent	No	Use contact first name from previous header record.
13	**Check for Contract Administrator e-mail information**	Email address present	No	Continue process
		Email address absent	No	Use email address from previous header record.
14	**Check for Primary Technical Contact Last name**	Name present	No	Continue process
		Name absent	No	Use Technical Last name from previous header record.
15	**Check for Primary Technical Contact First name**	Name present	No	Continue process
		Name absent	No	Use Technical First name from previous header record.
16	**Check for Primary Technical Contact e-mail information**	Name address present	No	Continue process
		Name address absent	No	Use email address from previous header record
17	**Compare number of detail records shown in Header record to the number of detail records contained in the submission**	The numbers are equal	No	Continue process
		Numbers are not equal	Yes	Transmit e-mail to HMO stating submission failed to load due to a header record error
				Loading process stopped
18	**Update contact table with information in header record**	Information is updated.	No	
19	**No additional actions**	Header record loading is complete	Yes	Begin detail record loading process

11.4 Header Record Loading Flowchart

1. Single error, resolved in March reconciliation

Erred Record Table	Submission Period	RIN	Record Type	Edits	EDS Process Date	Corrected Date	Aging Date	Aging Category
	January	11223344	O	0307	01/10/2000	Blank	02/01/2000	2
						03/25/2000		

Reconciliation processed on March 25. Edit 0307 resolved.

Accepted Record Table	Submission Period	RIN	Record Type	Edits	EDS Process date
	March	11223344	O		03/25/2000

2. Multiple errors, partially resolved in March reconciliation

Erred Record Table	Submission Period	RIN	Record Type	Edits	EDS Process Date	Corrected Date	Aging Date	Aging Category
	January	11223344	O	0208 0307	01/10/2000	Blank	02/01/2000	
						03/25/2000		2

Reconciliation processed on March 25. Edit 0307 resolved, edit 0208 remains. Original Aging Date retained.

	March	11223344	O	0208	03/25/2000	Blank	02/01/2000	2
						05/09/2000		4

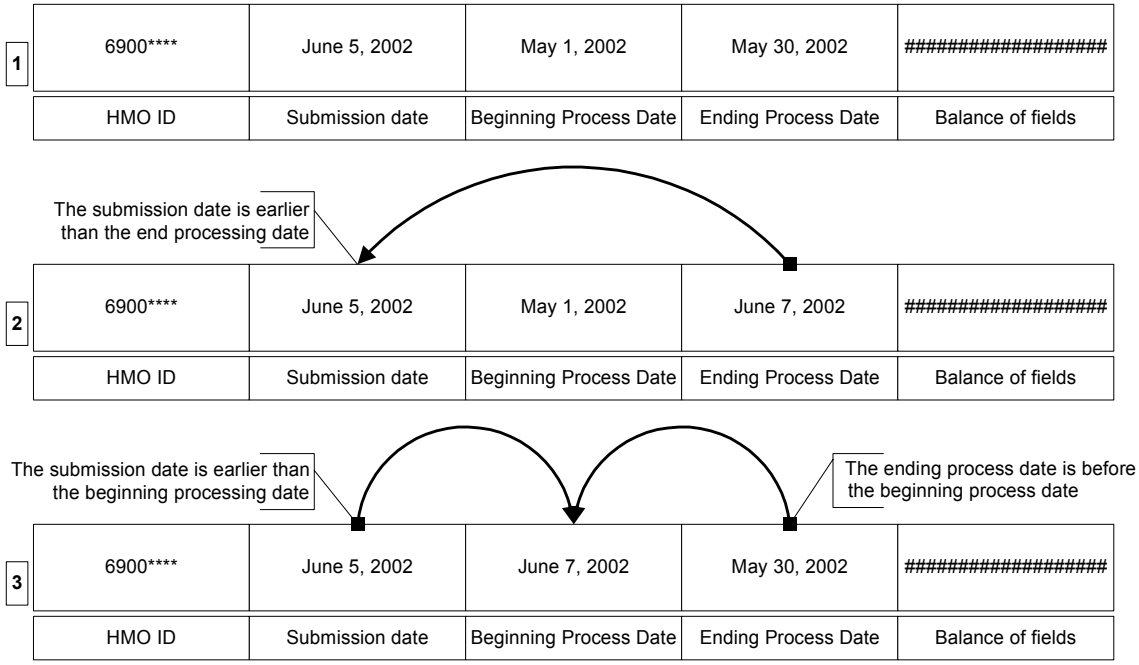
May submission corrects the remaining 0208 edit.

Accepted Record Table	Submission Period	RIN	Record Type	Edits	EDS Process Date
	May	11223344	O		05/09/2000

Legend	
	Information not stored in any table
	Fields appended and populated during editing of record
	Field information provided by HMO

11.5 Header Record Date Field Relationships

The following are 3 examples of header records. Two of the three submissions will fail to load. In submission #1, the date fields pass all edits and record is accepted. In submission #2, it shows that the file contains records processed 2 days after the submission date. In submission #3, two date relationship edits fail. In both cases, the HMO must send a new submission. A header record edit failure will cause the entire submission to be rejected.



11.6 Detail Record Loading

Detail records are loaded immediately after the successful loading of the header record. Each detail record goes through a series of system checks for length and valid ASCII characters. The process performs data validity checks on the fields and records failing this aspect of the process are copied to the bad records table. These records appear in the Bad Records section of the SSR. The detail loading process also checks for duplicate records within the same submission and/or duplicate records from previous submissions. (Please refer to Submission Status Report section for detailed information regarding 'Bad' and 'Duplicate' records). The remaining records are then parsed and loaded and the field editing process begins.

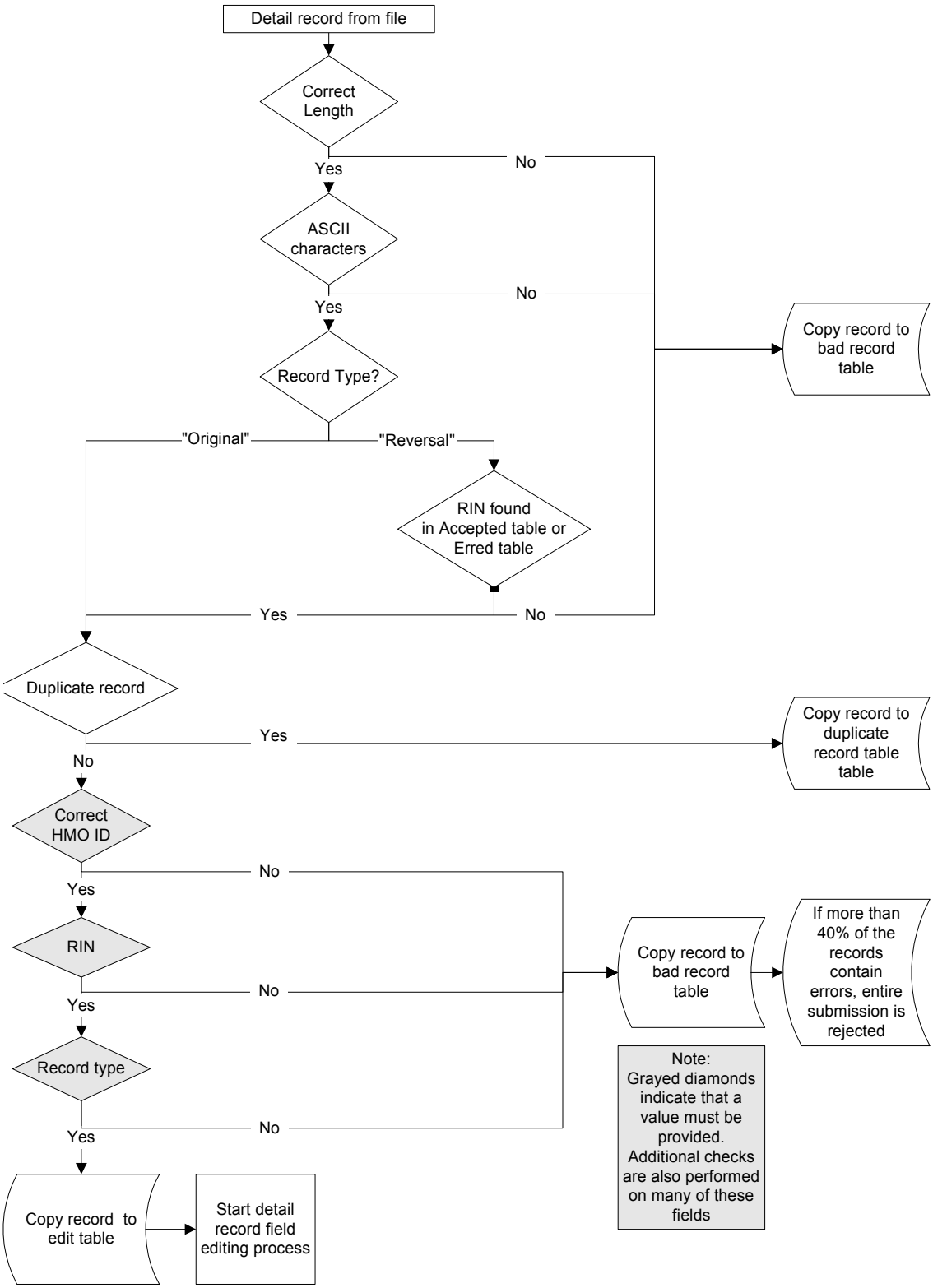
Detail Record Loading

Number	Action	Result	Log Entry	Additional action
1	**Select second record in the submission. Record must be 722 bytes in length**	Record is 722 bytes in length	No	Continue process
		Record does not contain 722 bytes, do not load the record.	Yes	Write record to the Bad records table
				Append date to entry
				Display in the Submission Status Report (SSR)
2	**Check record for non-ASCII characters**	All characters ASCII	No	Continue process
		If non-ASCII characters present, do not load record.	Yes	Write record to the Bad record table
				Append date to entry
				Display in the Submission Status Report (SSR)
3	**Check for valid HMO ID**	HMO ID present	No	Continue processing
		HMO ID missing/invalid/does not match the HMO ID in the header record	Yes	Write record to the Bad records table
				Append date to entry
				Display in the Submission Status Report (SSR)
4	**Check Record Identification Number (RIN)**	RIN present	No	Continue process
		RIN missing.	Yes	Write entire record to the bad records table
				Append date to entry
				Display in the Submission Status Report (SSR)
5	**Check record type (RT)**	RT present	No	Continue process
		RT missing/invalid	Yes	Write entire record to the bad records table
				Append date to entry
				Display in the Submission Status Report (SSR)

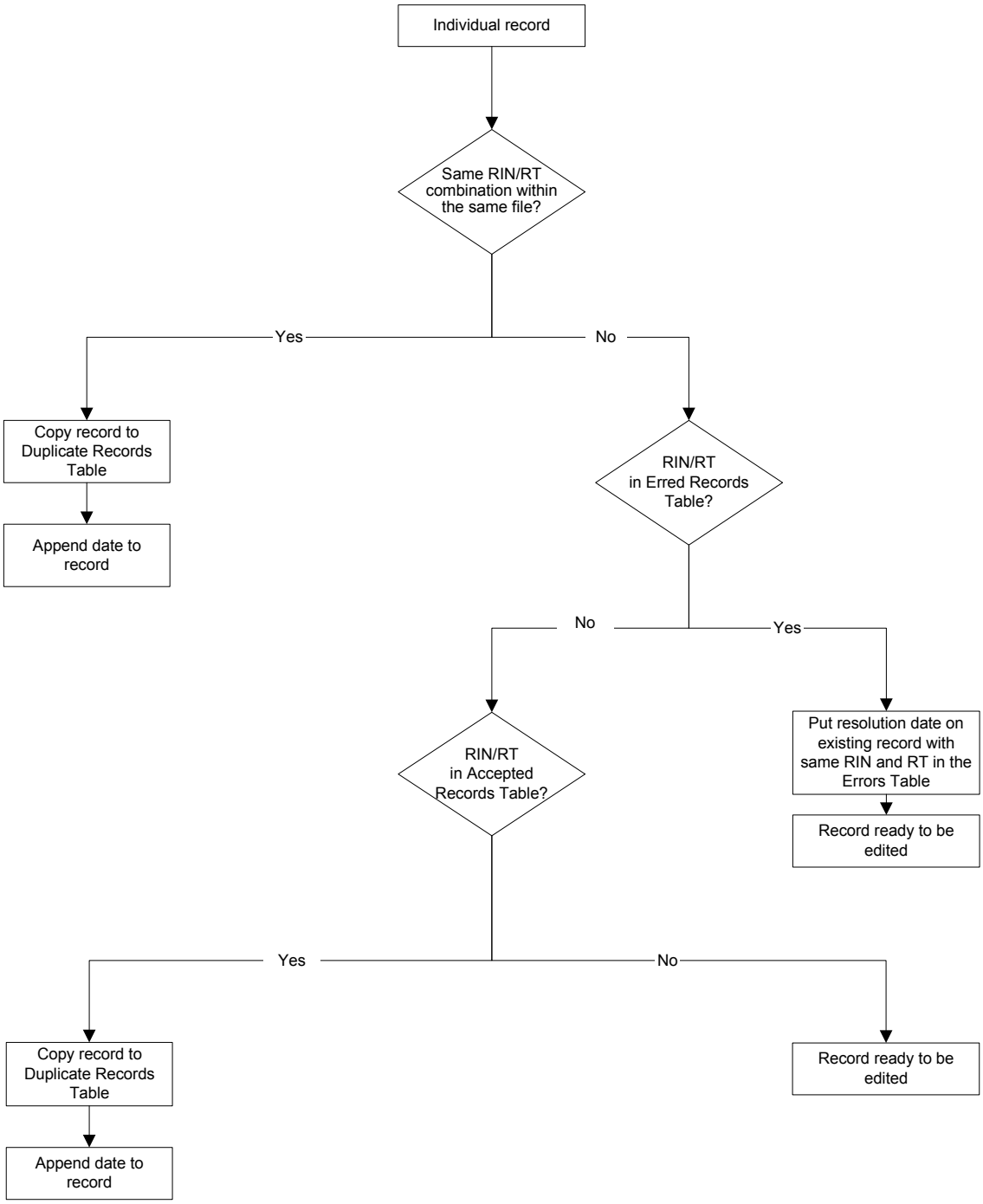
Detail Record Loading

Number	Action	Result	Log Entry	Additional action
6	**Check if record type is "R", there must be a matching RIN with a record type of "O" in the accepted or errors table or current submission**	Record present	No	Continue process
		No matching record	Yes	Write entire record to the bad records table
				Append date to entry (Note: Technically this check for the presence of an original record occurs right before field editing (#11.)
				Display in the Submission Status Report (SSR)
7	**Check for duplicate RIN/RT combination within same submission**	No duplicate records present in submission	No	Continue process
		Duplicate records present in submission	Yes	Write duplicate HMO ID, RIN and Record type to duplicate records table.
				Append date to entry
				Display in the Submission Status Report (SSR)
8	**Check for duplicate RIN/RT combination in accepted records table**	No duplicate combination found in accepted records table	No	Continue to number 9
		Duplicate combination found in accepted records table	Yes	Write duplicate HMO ID, RIN and Record type to duplicate records table
				Append date to entry
				Display in the Submission Status Report (SSR)
9	**Check for duplicate RIN/RT combination in erred records table where corrected date is "null"**	No duplicate combination found	No	Continue to number 10
		Duplicate combination found	Yes	Append date to first RIN already in erred records table, showing when corrected RIN was submitted.
10	**Check for loading edit failures**	Failures below 40%	No	Continue processing
		Failures exceed 40%	Yes	Loading of detail records cease.
				Notify HMO that submission failed to load due to excessive detail record loading failures
				Notify HMO Support Group
11	**Record ready for field editing**		No	Begin field editing process

11.6.1 Detail Record Loading Flowchart



11.6.2 Duplicate Record Check Flowchart



12 Field Editing

12.1 Overview

Editing is a critical piece of the encounter data processing system. Editing occurs at different stages throughout the processing system and approximately 200 edits exist to evaluate the integrity of the data.

12.2 Types of Edits

12.2.1 Header Loading Edits

Header loading edit checks occur at the time the file is being loaded into the encounter system for processing. Once a single header loading edit failure occurs, the entire submission fails. The HMO receives an automated email response with a message saying why the submission failed to load. The necessary corrections must be made and the file resubmitted for processing.

12.2.2 Detail Loading Edits

Detail loading edit checks also occur at the time the file is being loaded. Detail loading edits cause the transmission to fail only if 40% or greater of the detail records contain loading detail failures. Examples of detail loading edits:

1) Alpha/numeric appropriate ASCII characters
2) Incorrect detail record length
3) Invalid or missing HMO ID, Record Type, or RIN

12.2.3 Detail Field Edits

Detail field edits are used to check detail encounter record data. Each data element on the encounter record must pass certain edit criteria such as:

1) Required & Required If Applicable vs. Optional and Never Required fields for a particular encounter type
2) Valid values (i.e. procedure, diagnosis codes)
3) Appropriate relationships between fields on the record (i.e. Billing Provider is required if Performing Provider is blank)

12.3 Critical Edits vs. Non-critical Edits

12.3.1 Overview

An encounter submission contains 103 fields of information. Nearly 200 edits are in place to check the integrity of these fields. The accuracy of the information supplied is essential for the record to be of value. In a few, rare instances it is beneficial, but not essential, that data pass through all editing criteria. In these rare instances, an alternative data source is available to the state. This difference in data requirements allows us to classify edits into two edit types, ***critical*** edits and ***non-critical*** edits. The fundamental difference between the two edit types is the expectation of correction.

12.3.2 Critical edits

It is expected that records failing critical edits will be corrected. Records failing critical edits are stored in the erred records table. The erred records appear in the error and aging sections of the Submission Status Report (SSR). These records remain in the erred records table until the HMO submits either a record free of critical errors or a reversal record. Once the HMO submits an acceptable replacement record, it is

recorded that the erred record has been corrected. The erred record no longer appears in the Aging Section of the SSR. The majority of encounter edits fall into this edit type of critical.[1]

12.3.3 Non-critical edits

There are 3 general conditions that necessitate the existence of non-critical edits. The **first condition** occurs because of the timing of information updates. An encounter record represents an event at a fixed point in time. The information at the time the event took place is accurate. Between the time of the event and the time of the editing, changes in member names and member eligibility are common. If an HMO provides a service to a member that is retroactively disenrolled, the record will fail the member eligibility edits.

The **second condition** occurs because of lapses in provider certification. HMOs receive a monthly update about their providers. Within the month a provider's certification may lapse. Unless the provider notifies the HMO directly, the HMO will not be aware of this lapse until the following month. As soon as the condition that brought about the lapse is resolved, the provider is again certified. But there is no way to remove the lapse from the provider's eligibility profile. The record will fail the provider certification edits.

The **third condition** occurs when the DHCAA has determined a data element needs monitoring prior to making it a critical edit. This may occur when a new edit is instituted or when HMOs have expressed a concern with a particular data element. (I.e. National Type of Service is an example of this type of data element).

Non-critical edits do not require correction from the HMO. Records with values that have failed non-critical edits are essentially records where the HMO either cannot correct the record or the information is not vital for processing.

Records with non-critical edits will appear in the accepted section of the SSR unless the same record also incurred a critical edit. In this case, the record is sent to the erred records table and the non-critical edit failure will appear there. This keeps the errors together until the critical edit is corrected. Once the critical edit is corrected, the record is sent to the accepted table still displaying the non-critical edit.

If the HMO feels that an error has legitimately occurred on records failing non-critical edits, a corrected record should be submitted.

[1] There is one important distinction that needs to be mentioned in this discussion. Encounter records containing critical errors do not require correction if the record contains an NCPDP reject code on pharmacy records or certain ANSI codes on non-pharmacy records. A complete discussion of NCPDP and ANSI codes and their impact on records can be found in their respective sections of this guide. A list of ANSI codes with their disposition “Correction Required” or “No Correction Required” is located in the appendices.

12.4 Field Attributes

It is important to note that each field on the data record has been established as one of the following four attributes:

- Required
- Required if Applicable
- Optional
- Never Required

(For more information on encounter specific field requirements see Appendix B for the detail record file layout.)

12.4.1 Field Attribute Examples

When a field is ***required*** for a specific encounter type it means this data element must be present for the record to pass the edit criteria in place for that encounter type.

EXAMPLE - *REQUIRED*

Encounter Type	Field Name	Field Attribute Description
P = Pharmacy	**Fill date**	Fill date is a ***required*** field only on pharmacy encounters
I = Inpatient	**Admission date**	Admission date is a ***required*** field only on inpatient encounters

When a field is ***required if applicable*** for a specific encounter type it means this data element may or may not be required for the conditions present on the record. For example, both the billing and Performing Provider NPI fields are ***required if applicable*** for each encounter type. This is because one of the two must be present on every encounter record. If the billing provider NPI is blank, the Performing Provider NPI is required, and vice versa. Another example of ***required if applicable*** are Diagnosis Code #2 through Diagnosis Code #18. If additional diagnosis codes are available for the encounter, these fields need to be populated.

EXAMPLE – *REQUIRED IF APPLICABLE*

Encounter Type	Field Name	Field Attribute Description
M = Medical	**Performing Provider ID**	Performing provider ID is ***required if*** Billing provider ID is blank on medical encounters
D = Dental	**Modifier 1 & 2**	Modifier is ***required for certain procedures*** on dental encounters

When a field is ***optional*** for a specific encounter type it means this data element may or may not be present and if it is not present, it will not fail any edit criteria. If an optional field is populated, it must pass certain editing criteria such as the validity of the value.

EXAMPLE - *OPTIONAL*

Encounter Type	Field Name	Field Attribute Description
All = All encounters	**Member middle initial**	This field is ***optional*** for all encounter types
P = Pharmacy	**Place of Service**	This field is ***optional*** for pharmacy encounter types

When a field is ***never required*** for a specific encounter type it means this data element is ignored during editing and loading. The element should be left empty.

EXAMPLE – *NEVER REQUIRED*

Encounter Type	Field Name	Field Attribute Description
P = Pharmacy	**Diagnosis**	A diagnosis is ***never required*** on pharmacy encounters
I = Inpatient	**Modifier 1**	A modifier code is ***never required*** for inpatient encounters

12.5 Edit Number Ranges

A special edit grouping was established during the creation of encounter data edits. The intent is to more easily recognize and group edit failures. For example, member edits will always appear in the 0100-0199 range; edits specific to pharmacy will always be in the range 0800-0899, range 0500-0599 is specific to UB-04 data elements. Please see the following edit range breakdown:

1 Loading Edits (header and detail)

Range	Area
9000-9099	Header loading edits
0700-0799	detail loading edits

2 Field Edits (detail only)

Range	Area
0100-0199	Member edits
0200-0299	Provider edits
0300-0399	Procedure/modifier/place and type of service
0400-0499	Diagnoses
0500-0599	UB04
0800-0899	Pharmacy
0900-0999	Date formats, etc.
1000-1099	MSDRG/quantity/charge
1500-1599	Emergency/family planning/health check indicators
1600-1699	ANSI/NCPDP codes
1700-1799	Encounter type specific (i.e. Encounter Type, Data Source)

See **Appendix I** for a list of all the field edits.

13 Submission Status Report

13.1 Overview

HMOs submit encounter data to the state on a monthly basis. EDS receives and processes HMO encounter data, and provides the HMO's with a status of their submission in an electronically transmitted flat ASCII file called the ***Submission Status Report (SSR)***. The SSR goes out to the HMO after processing of their submission is complete. This generally will occur within 3 business days from the time the submission is received.

The contents of the SSR, layout and transmission method were developed as a result of discussions among the State, HMOs, and EDS. It is a tool designed to help the HMO work with DHCAA in submitting quality data and meeting contractual obligations. The SSR also provides data the HMO can use for internal reporting/tracking.

13.2 Types of Records

The SSR is an electronically transmitted flat ASCII file that consists of six types of records each 289 bytes in length. The six types of records in this file are:

- Summary
- Aging
- Accepted
- Erred
- Bad
- Duplicate

13.3 SSR Record Order

The data string will be transmitted in the following order:

Name of the Section	Preceding Alpha Code Identifier	Length of Section (bytes)
Summary/YTD	S	213 + 80 filler
Aging/correction Records	X	32 per aging RIN + 261 filler
Detail Accepted Records	A	293 per accepted record
Detail Erred Records	E	270 per erred record + 23 filler
Bad Records	B	289 per bad record + 4 filler
Duplicate Records	D	50 per duplicate record + 243 filler
Pricing Records	P	292 pre priced record + 1 filler

13.4 Summary (S) SSR Record Section

The summary record is a snapshot of the HMO's number and type of records processed for the month, including year-to-date totals. The totals for this section are based on calendar year starting 01012001 and are cleared and restarted after the last SSR is generated at the end of 2001. The year-to-date totals for each record (Summary, Aging, Accepted, Erred, Bad, and Duplicate) are cumulative. Every month, the year-to-date totals will increment by the number of records that fit into each category. Year-to-date totals will never decrease. For example, when an HMO submits a correction of an erred record, this record now becomes an accepted record but the YTD total for erred records does not decrease.

Records in this section begin with the character S.

Summary/YTD (year to date) totals

The summary section will give you a snapshot of the number and type of records processed for the month as well as year-to-date totals.

Field Name	Starting position	Ending position	Field Size
SSR Record Designation (summary record = S)	1	1	1
HMO ID	2	9	8
HMO's Process Begin Date (mmddyyyy)	10	17	8
HMO's Process End Date (mmddyyyy)	18	25	8
Date Received by EDS	26	33	8
Total Records Received	34	43	10
Total Records Received YTD	44	53	10
Total Accepted Records	54	63	10
Total Accepted Records YTD	64	73	10
Total Erred Records	74	83	10
Total Erred Record YTD	84	93	10
Total Bad Records Failing Load	94	103	10
Total Bad Records Failing Load YTD	104	113	10
Total Duplicate Records	114	123	10
Total Duplicate Records YTD	124	133	10
Submitted Zip File Name	**134**	**173**	**40**
Submitted Unzip File Name	**174**	**213**	**40**
Filler (space filled)	214	293	**80**

13.5 Aging (X) SSR Record Section

The aging record identifies the RIN and age (1 to over 120 days) of encounter records pending correction. If there are no aging RINs, this record will not exist. Likewise, if there are aging RINs only in the '2' category (31-60 days), just that category will be transmitted. Unlike the summary record, the number of aging records will increase and decrease, depending on the number of previously submitted erred records that have been successfully corrected. For example when the HMO resubmits their erred record(s) in a subsequent month's submission, the aging record section will no longer carry the successfully corrected RINs. The successfully corrected RINs will appear in the accepted section of the SSR.

*Records that do not meet all editing requirements will continue to age from the **original date it failed the error**, until a correction is successfully applied to the record.*

Records in this section begin with the character X.

13.5.1 Aging Categories

Aging Records: The aging record section will inform you of the age of each RIN pending correction. Each aging record will be preceded by a code specifying the number of days the RIN has been waiting for correction.

1=01-30 days

2=31-60 days

3=61-90 days*

4=91-120 days**

5=121 + days **

* *Aging RINs in this category '3' are subject to penalties/fines **if** they are not corrected by the next month's submission.*

***Penalties/fines may be incurred on any erred record aging over 90 days.*

Field Name	Starting position	Ending position	Field size
SSR Record Designation (aging record = X)	1	1	1
Aging Category, 1,2,3,4,or 5	2	2	1
HMO's RIN	3	32	30
Filler (space filled)	33	293	261

13.5.2 Aging Examples

1. Single error, finally resolved in May submission

Erred Record Table

Submission period	Record identification Number	Record type	Errors qty.	Process date	Corrected date	Aging date	Aging category
January	11223344	O	Yes (1)	01/10/2000	03/12/2000	02/01/2000	1
March	11223344	O	Yes (1)	03/12/2000	04/13/2000	02/01/2000	2
April	11223344	O	Yes (1)	04/13/2000	05/15/2000	02/01/2000	3

Accepted Record Table

Submission period	Record identification Number	Record type	Errors qty.	Process date
May	11223344	O	No	05/15/2000

2. Multiple errors, last error resolved in May submission

Erred Record Table

Submission period	Record identification Number	Record type	Errors qty.	Process date	Corrected date	Aging date	Aging category
January	11223344	O	Yes (4)	01/10/2000	03/12/2000	02/01/2000	1
March	11223344	O	Yes (2)	03/12/2000	04/13/2000	02/01/2000	2
April	11223344	O	Yes (1)	04/13/2000	05/15/2000	02/01/2000	3

Accepted Record Table

Submission period	Record identification Number	Record type	Errors qty.	Process date
May	11223344	O	No	05/15/2000

Legend

	Information not stored in any table
	Fields appended and populated during editing
	Field information provided by HMO

13.6 Accepted (A) SSR Record Section

The accepted record section displays all records that have been edited, accepted and placed in the data warehouse for utilization and data quality analysis. This record is made up of selected data elements taken from the actual encounter record. The intent of showing these data elements is to give a snapshot of what was transmitted from the HMO to EDS. Errors may appear in the accepted record section but **do not require correction**. Information about any errors that fail within an accepted record begins in position 119.

Special Considerations:

1) When an original record is reversed both the original and reversal RINs appear in the accepted section of the SSR to show the original record was reversed.
2) Non-critical errors (errors that do not require correction) appear in the accepted section with one exception. When a critical edit fails in conjunction with a non-critical, the record will be sent to the error table. This keeps the record together until the critical edit is corrected. A RIN is never split between the accepted and erred sections. It will appear in one or the other.
3) Records containing ANSI codes that do not require correction appear in the accepted section as well as pharmacy records containing NCPDP codes. The record displays the error that failed, but because of the presence of the ANSI/NCPDP code, no correction is expected.

Records in this section begin with the character A.

Field Name	Starting position	Ending position	Field size
SSR Record Designation (accepted record = A)	1	1	1
Encounter Type	2	2	1
HMO ID	3	10	8
Record Type	11	11	1
Record Identification Number (RIN)	12	41	30
HMO Process Date	42	49	8
Billing Provider NPI	50	59	10
Member ID	60	69	10
Assigned MSDRG	70	73	**4**
From Date of Service	74	81	8
Place of Service	82	83	2
HCPCS/NDC/Revenue Code	84	94	11
Modifier 1	95	96	2
Modifier 2	97	98	2
Quantity	99	107	9
ANSI/NCPDP code #1	108	110	3
ANSI/NCPDP code #2	111	113	3
ANSI/NCPDP code #3	114	116	3
ANSI/NCPDP code #4	117	119	3

Field Name	Starting position	Ending position	Field size
Error code Number	120	123	4
Explanation of Error code	124	198	75
Record Error Type (C = Critical, N = Non-critical)	199	199	1
Field Number	200	201	2
Field Name	202	236	35
Value in field that erred	237	271	35
Group ID	**272**	**279**	**8**
Allowed Amount	**280**	**288**	**9**
Pricing Indicator	**289**	**293**	**5**

13.7 Erred (E) SSR Record Section

Records in the erred record section have failed at least one critical edit. There is an expectation erred records will be corrected and resubmitted within 90 days. These corrections are sent as part of the normal monthly submission. Like the accepted record, the erred record is made up of selected data elements taken from the actual encounter record. Erred records will always display an error code starting in position 119. Special considerations for the erred record include:

1) Records with critical error codes will always appear in the erred section of the SSR. The record ages until a correction is successful.
2) Multiple RINs will appear in the error record if more than one error has occurred on the record. ***The distinct error record count in the summary section of the SSR will increment by one per RIN, not one per error per RIN.***
3) As mentioned in the accepted section, when non-critical and critical edits fail on the same record, the RIN will appear in the Erred section of the SSR. A RIN is never split between the accepted and erred sections. It will appear in one or the other.
4) Non-critical error codes on records in the erred section do not require correction and will only appear in the erred section until the critical error is corrected.

Records in this section begin with the character E.

Field Name	Starting position	Ending position	Field size
SSR Record Designation, (erred record = E)	1	1	1
Encounter Type	2	2	1
HMO ID	3	10	8
Record Type	11	11	1
Record Identification Number (RIN)	12	41	30
HMO Process Date	42	49	8
Billing Provider NPI	50	59	**10**
Member ID	58	67	10
From Date of Service	73	80	8
Place of Service	81	82	2
HCPCS/NDC/Revenue Code	83	93	11
Modifier 1	94	95	2
Modifier 2	96	97	2
Quantity	98	106	9
ANSI/NCPDP code #1	107	109	3
ANSI/NCPDP code #2	110	112	3
ANSI/NCPDP code #3	113	115	3
ANSI/NCPDP code #4	116	118	3
Error Code Number	119	122	4
Explanation of Error Code	123	197	75

Field Name	Starting position	Ending position	Field size
Record Error Type (C = Critical, N = Non-critical)	198	198	1
Field Number	199	200	2
Field Name	201	235	35
Value in field that erred	236	270	35
Filler (space filled)	271	293	**23**

13.8 Bad (B) SSR Record Section

Records appearing in the bad record of the SSR have failed some type of detail loading requirement. Bad records contain the first 137-bytes of the record, in addition to the error code/explanation. An example of a bad record is when the entire record is short by one byte, or the record is missing an essential piece of information such as the HMO ID. **NOTE:** Bad records (loading errors) are not sent to the aging section of the SSR. This is because they are never loaded and processed through the encounter editing system. The HMO will have to resubmit these records to be processed and counted as an encounter if these records were meant to portray a valid encounter between a ForwardHealth enrollee and a provider.

Records in this section begin with the character B.

The bad record section shows records that have failed loading requirements.

Field Name	Starting position	Ending position	Field size
SSR Record Designation (bad record = B)	1	1	1
Record Data String*	2	138	137
Error Code Number	139	142	4
Explanation of Error Code	143	217	75
Field Number	218	219	2
Field Name	220	254	35
Value in field that erred	255	289	35
Filler (space filled)	**290**	**293**	**4**

* The data string consists of the first 137 bytes of the record with appropriate spacing. This string of data will help identify which record was bad/unloadable.

13.9 Duplicate (D) SSR Record Section

Records appearing in the duplicate record of the SSR have been determined to be a duplicate of another record. Duplicate records are erred and sent to the duplicate record of the SSR. A record is considered a duplicate, when:

1. More than one record is transmitted in the same submission with the same RT (record type) and RIN (record identification number)
2. A record(s) is submitted with a RIN and RT combination that has already been processed and placed in the accepted table.

Records in this section begin with the character D.

Field Name	Starting position	Ending position	Field size
SSR Record Designation (duplicate record =D)	1	1	1
Record Identification Number (RIN)	2	31	30
Record Type	32	32	1
Date of Duplicate RIN	33	40	8
Member ID	41	50	10
Filler (space filled)	51	293	**243**

14 Record Correction Methods

There are three situations where record correction is needed:
1. A valid, edit-free record needs to be removed by the HMO.
2. A HMO receives updated information and wishes to update previously submitted records.
3. The editing process identifies errors in a record submitted by an HMO.

14.1 Record Correction Examples

EXAMPLES

1	**Issue**	An HMO submits an encounter record. The record passes all edits and is accepted. After further review, the HMO determines that the encounter should not have been submitted. The HMO wants to remove the record.
	Solution	The HMO submits 1 record, a "reversal" record that negates the accepted record.
2	**Issue**	An HMO submits an encounter record. The record passes all edits and is accepted. After further review, the HMO determines that the encounter should have been denied. The HMO wants to update the information in the record.
	Solution	The HMO submits 2 records, a "reversal" record that negates the accepted record and a new "original" record with the updated information
3	**Issue**	An HMO submits an encounter record. The record fails a critical field edit and is placed in the Erred Records Table. The HMO needs to correct the erred record.
	Solution	The HMO submits one reversal to reverse the erred record and one replacement original record .

14.2 Reversal Record Required Fields

There are only four required fields in a reversal record. The fields are:
- HMO ID
- Record Type
- Record Identification Number (RIN)
- Process Date

It is important to remember that the record length of a reversal record is the same as an original record. It is also necessary to use the proper fill characters, depending on the field. Numeric fields are filled with zeros and alpha/numeric fields are space filled.

EXAMPLE 1 Reversal of an accepted Encounter Record

a.

- An encounter record is submitted on November 9th 2007.
- The encounter passes all critical edits and is added to the accepted table.

Table 1 Accepted Encounter Record

HMO_ID	RIN	EDS PROC DATE	SAK_ ENCOUNTER	SAK_SUB_ SUMMARY	REC_ TYPE	EDS PROC DATE	EDS_ REVERSAL DATE	EDIT TYPE
69000230	200704160196463RZAF	09-NOV-07	4000389	3045	O	09-NOV-07		N

b.

- A reversal record is submitted on November 9th 2007 to correct some data in the accepted encounter record.
- The reversal record MUST have the same HMO ID, RIN, EDS Process Date and a record type of 'R' as shown in Table 2.

Table 2. Reversal Record

HMO_ID	RIN	EDS PROC DATE	REC_ TYPE	EDS PROC DATE
69000230	200704160196463RZAF	09-NOV-07	O	09-NOV-07

c.

- The reversal record is processed and a match is found on the accepted table for the HMO ID, RIN and EDS Process date of the reversal.
- The accepted table is updated by adding the reversal record.
- The EDS reversal date for the accepted reversal record is set to the EDS process date of the reversal.
- The presence of the EDS Reversal date will prevent this encounter from being available for future reversals.
- The reversal record values can be seen in Table 3 this record is identified by the HMO ID, RIN, EDS process date, a record type of 'R' and a reversal process date equal to the EDS process date.

Table 3 Accepted Table

HMO_ID	RIN	EDS PROC DATE	SAK_ ENCOUNTER	SAK_SUB_ SUMMARY	REC_ TYPE	EDS PROC DATE	EDS_ REVERSAL DATE
69000230	200704160196463RZAF	09-NOV-07	4000389	3045	O	09-NOV-07	16-NOV-07
69000230	200704160196463RZAF	16-NOV-07	4000393	3046	R	16-NOV-07	16-NOV-07

EXAMPLE 2 Reversal of an accepted Encounter Record

a.

- An encounter record is submitted on November 9th 2007.
- The encounter passes all critical edits and is added to the accepted table.

Table 1 Accepted Encounter Record

HMO_ID	RIN	EDS PROC DATE	SAK_ ENCOUNTER	SAK_SUB_ SUMMARY	REC_ TYPE	EDS PROC DATE	EDS_ REVERSAL DATE
69000230	200704160196463RZAF	09-NOV-07	4000389	3045	O	09-NOV-07	

b.

- A reversal record is submitted on November 9th 2007 to correct some data in the accepted encounter record.

– The reversal record MUST have the same HMO ID, RIN, EDS Process Date and a record type of 'R' as shown in Table 2.

Table 2. Reversal Record

HMO_ID	RIN	EDS PROC DATE	REC_ TYPE	EDS PROC DATE
69000230	200704160196463RZAF	09-NOV-07	O	09-NOV-07

c.

– The reversal record is processed and a match is found on the accepted table for the HMO ID, RIN and EDS Process date of the reversal.
– The accepted table is updated by adding the reversal record.
– The EDS reversal date for the accepted reversal record is set to the EDS process date of the reversal.
– The presence of the EDS Reversal date will prevent this encounter from being available for future reversals.
– The reversal record values can be seen in Table 3 this record is identified by the HMO ID, RIN, EDS process date, a record type of 'R' and a reversal process date equal to the EDS process date.

Table 3 Accepted Table

HMO_ID	RIN	EDS PROC DATE	SAK_ ENCOUNTER	SAK_SUB_ SUMMARY	REC_ TYPE	EDS PROC DATE	EDS_ REVERSAL DATE	EDIT TYPE
69000230	200704160196463RZAF	09-NOV-07	4000389	3045	O	09-NOV-07	16-NOV-07	N
69000230	200704160196463RZAF	16-NOV-07	4000393	3046	R	16-NOV-07	16-NOV-07	N

d.

– A new original encounter record was submitted in the same submission with the same HMO ID, RIN, EDS process date as the original record to be corrected and a record type of 'O'.
– The new encounter record is processed through all of the encounter edits and if all of the criteria is met for the adding the encounter to the accepted table the encounter is added to the table.
– The newly accepted encounter records will have a NULL EDS Reversal date and an encounter type of 'O'.
– The new accepted encounter record values can be seen in Table 4 this record is identified by the HMO ID, RIN, EDS process date, a record type of 'O' and a reversal process date that is null.

Table 4 Accepted Table

HMO_ID	RIN	EDS PROC DATE	SAK_ ENCOUNTER	SAK_SUB_ SUMMARY	REC_ TYPE	EDS PROC DATE	EDS_ REVERSAL DATE	EDIT TYPE
69000230	200704160196463RZAF	16-NOV-07	4000397	3046	O	16-NOV-07		

e.

– The resulting records in the accepted table after the reversal and new original records are submitted will appear in the accepted table with the values as shown in table 5.

Table 5 Accepted Table

HMO_ID	RIN	EDS PROC DATE	SAK_ ENCOUNTER	SAK_SUB_ SUMMARY	REC_ TYPE	EDS PROC DATE	EDS_ REVERSAL DATE	EDIT TYPE
69000230	200704160196463RZAF	09-NOV-07	4000389	3045	O	09-NOV-07	16-NOV-07	N
69000230	200704160196463RZAF	16-NOV-07	4000393	3046	R	16-NOV-07	16-NOV-07	N
69000230	200704160196463RZAF	16-NOV-07	4000397	3046	O	16-NOV-07		

EXAMPLE 3 Reversal of an encounter on the Error table.

a.

- An encounter record is submitted on September 8h 2008.
- The encounter did not pass all critical edits and is added to the error table (table 1).

Table 1 Error Table

HMO_ID	RIN	SAK_ ENCOU NTER	SAK_SU B_ SUMMA RY	REC_ TYPE	AGING DATE	EDS PROC DATE	Corrected Date	EDS_ REVERSAL DATE
69004600	9419870898U1	4000416	3058	O	01-OCT-08	08-SEP-08		

b.

- A second encounter original record is submitted with a record type of 'O' and the same HMO ID, RIN and EDS process date and corrected information (Table 4).
- The error record for this HMO ID, RIN and EDS process date exists in the encounter error table and it does not have a EDS Reversal Date.
- The reversal date is added to the error record and the new Original encounter record is processed by encounter and passes all edits this encounter is added to the accepted table.
- reverses out and corrects the error record by adding the EDS reversal date and corrected date set to the new encounter records EDS process date.
- The new encounter record is added to the accepted table.
- The accepted encounter record does not have a reversal date because the record never existed on the accepted table.

Table 3. ERROR

HMO_ID	RIN	EDS PROC DATE	SAK_ ENCOU NTER	SAK_SU B_ SUMMA RY	REC_ TYPE	AGING DATE	EDS_ REVERSAL DATE	Corrected Date
69004600	9419870898U1	08-SEP-08	4000416	3058	O	01-OCT-08	10-SEP-08	10-SEP-08

Table 4 ACCEPTED TABLE

HMO_ID	RIN	EDS PROC DATE	SAK_ ENCOUNTER	SAK_SUB_ SUMMARY	REC_ TYPE	EDS PROC DATE	EDS_ REVERSAL DATE	EDIT TYPE
69004600	9419870898U1	10-SEP-08	4000425	3063	O	10-SEP-08		

Record Correction Rules

- Accepted Records can be reversed.
- Error records can be reversed.
- **Accepted, reversed record cannot be reversed again.**
- **Erred, reversed record cannot be reversed again.**
- **Accepted record can be reversed and replaced in same submission**
- **An Erred record can be reversed and corrected in same submission.**

The order of the reversal record and the new original record in the submission will not effect the outcome.

15 Encounter Data Reconciliation/Recycle Process

15.1 The Need for Reconciliation/Recycling

Many of the encounter data edits that are applied during encounter editing compare a value submitted by the HMO against a table of valid values that may have been defined nationally (e.g., HCPCS procedure codes, DRGs, etc.). If the value submitted by the HMO is not found on this table, then the encounter record fails an edit. These tables must be updated whenever the national organizations make a change to a code or value. Often, the timing of these changes does not perfectly coincide with the encounter data submission cycle.

For example, in a February 2001 encounter data submission, an HMO might include a record with a new HCPCS code, which was part of the national HCPCS update effective January 1, 2001. However, this new code was not added to the encounter tables until March 1, 2001. As a result, the encounter records with January dates of service that are submitted in February would improperly fail an edit. In fact, the value erring was correct.

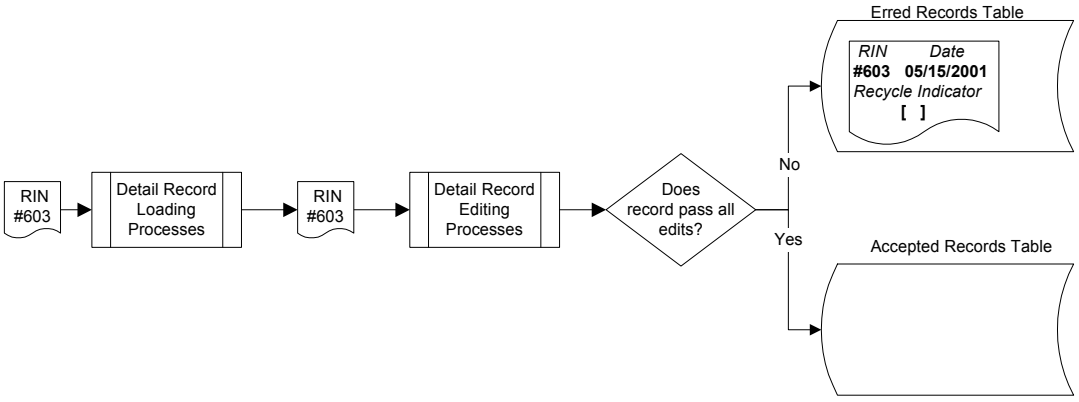
To address this and other situations when edits may have detected errors improperly, or when policy necessitates a revision to editing, a process called reconciliation was developed.

HMOs must provide a monthly submission between the 1st and 10th of each month. EDS loads, edits and generates reports between the time the submission is received and the 20th of the month. In an ideal situation, that would encompass the entire process. The reality of the situation is, discrepancies arise. The most common example for these discrepancies is the timeliness of updates. External organizations, such as CMS, ANSI, AMA, and the Uniform Billing Committee make changes to their data. When changes are received, the tables are updated. Unfortunately, the timing of these changes does not perfectly coincide with our submission schedule.

15.2 Overview of Reconciliation

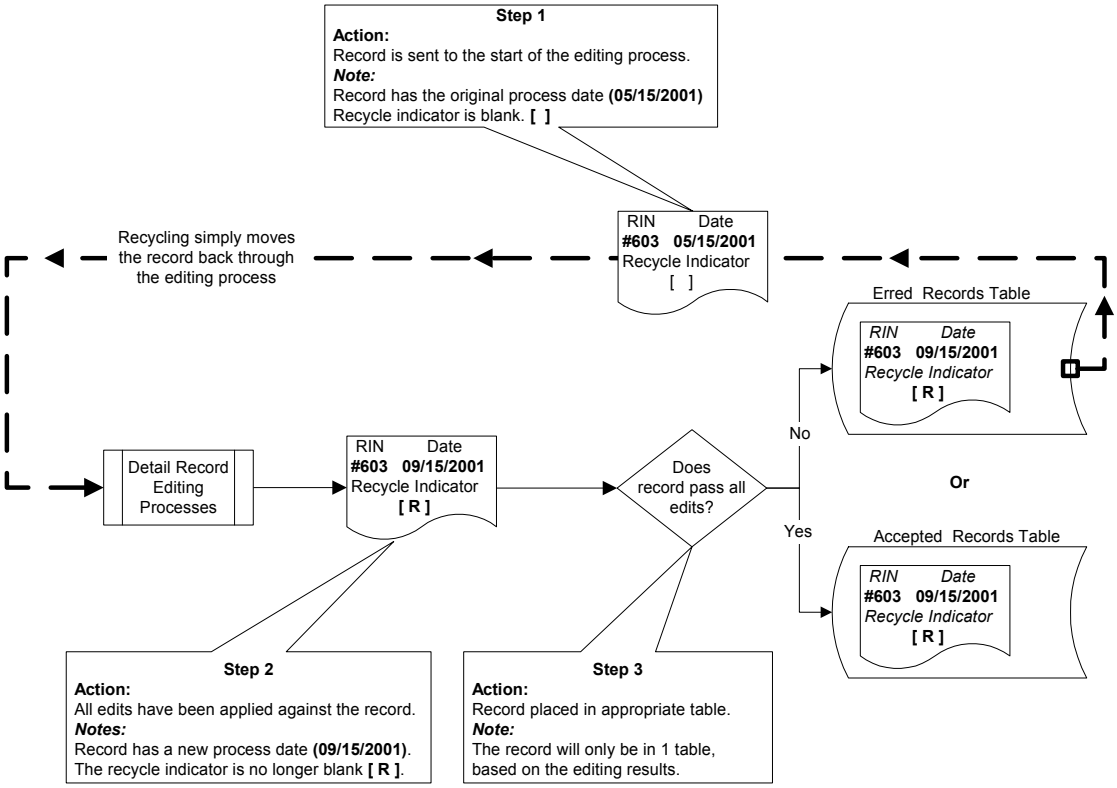
Reconciliation, also known as recycling, is a process that allows previously submitted records to be reprocessed. The state, HMOs, or EDS can make a request to recycle. The recycling process enables the DHCAA and EDS to work with the HMOs in an effort to provide the most accurate data to the end users. On the following page there is a graphic illustrating the process of recycling the record.

Initial Record Editing



Records may be recycled for a variety of reasons.
Once the decision is made to recycle a record, this is a representation of the process.

Recycle Record Editing



15.3 Reasons for Reconciliation

There are a number of reasons reconciliation may occur. Specific examples are listed below. Once the need to reconcile is identified, EDS will attempt to notify the HMOs of the upcoming process. The reconciliation process takes place in response to a request from an HMO or EDS that is approved by the State. Once the designated records are recycled, reports are distributed to all HMOs indicating the result of the reconciliation. *NOTE: It is important to understand a recycled record is run through the complete editing cycle. So, if the recycle process corrects one error but other errors linger, the record will continue to age and remain in the error table.*

15.4 Recycling Categories

There are 3 general categories of recycling: Edits, RIN, and Encounter type. In each situation, once the category is defined, all records that meet the definition are reprocessed. The reprocessing cycle may include one or more recycling categories. The results are grouped so that at the end of the recycling period, a single report is distributed to each impacted HMO.

Examples

Recycle by Edit

Many of the edits performed compare a value provided by the HMO to a value stored in a lookup table. As stated earlier, these lookup tables are frequently updated. There may be instances where the update takes place after a submission is processed. Rather than have the HMO research a value incorrectly identified as erroneous, all records that are identified as containing a specific edit are reprocessed

Recycle by Individual RIN

A HMO may request that a specific RIN be reprocessed. There are a number of reasons for this request. This may occur when a record has denied and an update has occurred since the initial processing, which allows the encounter to process through to the accepted table.

Recycle by Encounter Type

Recycle all encounter records that reside on error table for a particular encounter type (e.g. dental), regardless of HMO, for re-submission through the encounter editing system. This may occur when an Encounter-type-specific data element has been updated to include a new value.

15.5 HMO Reconciliation Request Process

An HMO may make a request for recycling at any time. To request an electronic reconciliation form, please contact the HMO Support Group to VEDSHMOSupport.@wisconsin.gov. Once a reconciliation is requested, EDS will research the request and communicate their findings to the State. If the request is approved, the requesting HMO and/or all HMOs that may be impacted by the recycling will be notified. If the findings do not support the need to recycle, the HMO will be informed via e-mail.

HMO Encounter Reconciliation Request Form

Request Date:

HMO Name:

Process Date:

HMO Contact:

HMO ID:

Requester:

Phone Number:

RIN #:

Edit #:

Member ID:

Begin/end Process Date

HMO E-mail Address:

Reason For Request:

For EDS use only:

DHCAA Response:

Approved/Denied:

EDS Reconciliation Date:

15.6 HMO Encounter Reconciliation Request Form Instructions

The following pieces of information must be complete in order to process reconciliation requests. Once the request has been reviewed, EDS will notify the HMO of DHCAA's decision. If DHCAA approves the request, EDS will notify the contact person on the request form that the request was granted and will be processed.

(R) = Always required or (RA) = Required if applicable

Request Date: **(R)** the date request was initiated.

RIN- (RA) record identification number if requesting specific encounters to be reconciled. RINs do not have to be listed out when the reconciliation is not RIN specific.

Process Date: (R) the date the records requested for recycling were processed by HMO.

Edit #: (RA) the edit number associated with the requesting reconciliation.

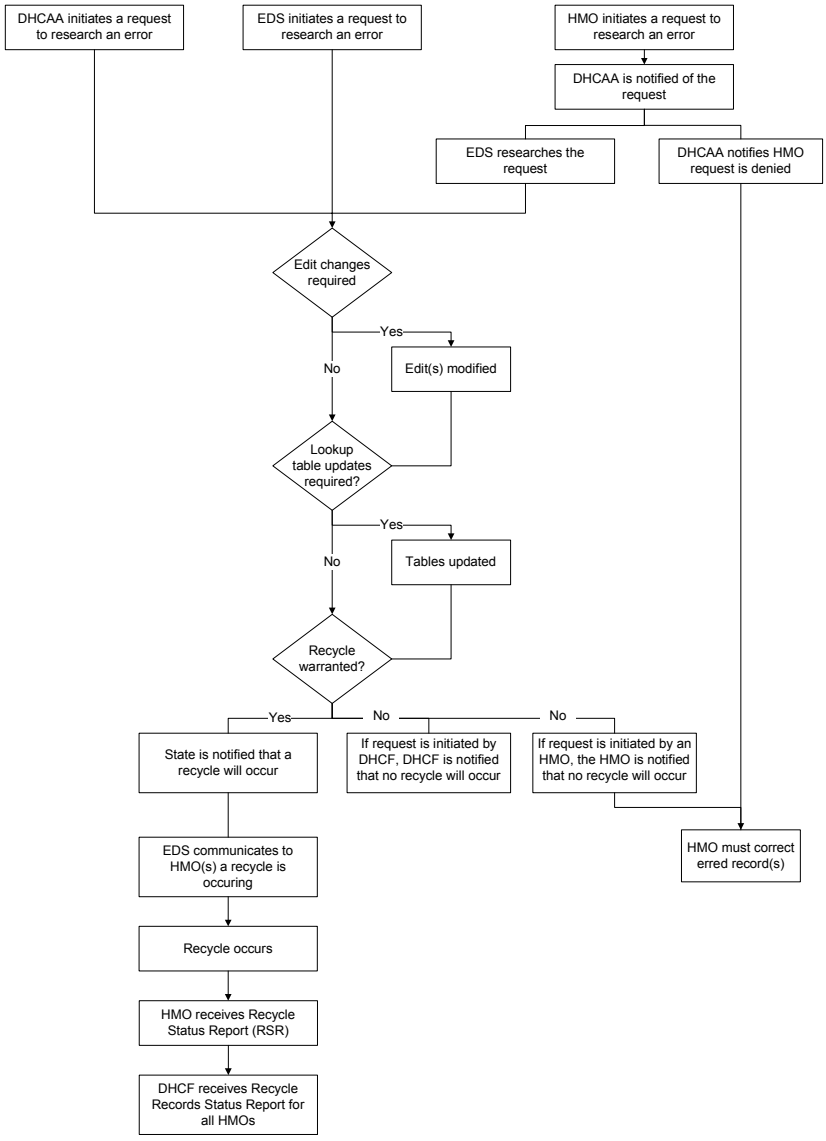
Member #: **(RA)** the member ID associated with the requested reconciliation.

Begin/end process date: (RA) the beginning and ending process dates of the submission that the records were initially processed in.

Reason for request: (R) detailed description of why you are requesting reconciliation.

15.7 Reconciliation Request Review Process

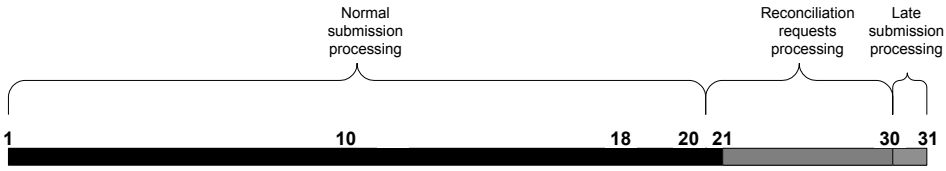
An HMO, DHCAA or EDS may initiate a request for reconciliation for various processing and/or end user needs. The following flowchart illustrates the process of reviewing a reconciliation request.



Overlapping Efforts

The Submission Status Reports will be distributed to all HMOs within three business days of submitting data. The reconciliation process will be run when approval is received from the State. It is a possibility that a HMO may be researching an erred record from the SSR at the same time a recycling is taking place. Every attempt will be made to notify HMOs as soon as a recycling is scheduled to reduce the possibility of an HMO unnecessarily working to correct records that will be recycled during the reconciliation process.

15.8 Reconciliation Timeline



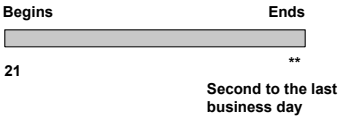
R1. Request for reconciliation

Note: A request for reconciliation can be made anytimg during the month: however, depending on when the request is received will drive when the reconciliation process actually takes place.

R2. Reconciliation Request Review Meeting

Note: The reconciliation will not take place prior to a review meeting with DHCCA.

R3. Reconciliation Process



Note: All reconciliation will be done prior to the Month End processing to assure that the reconciled encounters will be available for pricing.

R4. HMO Reconciliation Status Reports

Note: HMO Reconciliation Status Reports will be distributed once all reconciliation efforts are completed. This will take place sometime after the 20th. of the month. All reconciliation activities will be completed prior to the last day of the month.

R5. DHCF Reconciliation Summary Report

Note: Reconciliation status reports are produced at the completion of the reconciliation and will be delivered via the SFTP server to all effected HMOs.

15.9 Reconciliation Status Report (RSR)

The Reconciliation Status Report, (RSR), is distributed to all HMOs that have reprocessed records. If a HMO requests that a specific RIN be reprocessed, only that HMO would receive the results of the recycling. It is important to note that when a recycling of records occurs, the recycled records are not added into the numbers in the SSR. For example, if a record is recycled and is now accepted, the accepted record total in the SSR does not update. The SSR and RSR are stand-alone reports with separate totals.

15.10 Reconciliation Status Report File Layout

15.10.1 RSR Record Order

The data string will be transmitted in the following order:

Name of the Section	Preceding Alpha Code Identifier	Length of Section (bytes)
Summary/YTD	S	213 + 80 filler
Aging/correction records	X	32 per aging RIN + 261 filler
Detail Accepted Record	A	293 per accepted record
Detail Erred Record	E	270 per erred record + 23 filler
Bad Records	B	289 per bad record + 4 filler
Duplicate Records	D	50 per duplicate record + 243 filler
Bad Records	B	289 per bad record + 4 filler

15.10.2 Summary (S) RSR Record Section

Summary/YTD (year to date) totals: The summary section will give you a snapshot of the number and type of records processed through recycling as well as year-to-date totals.

Field Name	Starting position	Ending position	Field Size
RSR Record Designation (summary record = S)	1	1	1
HMO ID	2	9	8
HMO's Process Begin Date (mmddyyyy)	10	17	8
HMO's Process End Date (mmddyyyy)	18	25	8
Date Recycled by EDS	26	33	8
Total Records Recycled	34	43	10
Total Records Recycled YTD	44	53	10
Total Recycled Accepted Records	54	63	10
Total Recycled Accepted Records YTD	64	73	10

Field Name	Starting position	Ending position	Field Size
Total Recycled Erred Records	74	83	10
Total Recycled Erred Record YTD	84	93	10
Total Bad Records Failing Load	94	103	10
Total Bad Records Failing Load YTD	104	113	10
Total Duplicate Records	114	123	10
Total Duplicate Records YTD	124	133	10
Submitted Zip File Name	**134**	**173**	**40**
Submitted Unzip File Name	**174**	**213**	**40**
Filler (space filled)	214	293	**80**

15.10.3 Aging (X) RSR Record Section

Aging Records: The aging record section will inform you of the age of each RIN pending correction. The aging section reflects the status of all records after the recycling has taken place. Each aging record is preceded by a code specifying the number of days the RIN has been waiting for correction. If there are no aging RINs after completion of the recycling process, this record will not exist.

Field Name	Starting position	Ending position	Field size
RSR Record Designation (aging record = X)	1	1	1
Aging Category, 1,2,3,4,or 5	2	2	1
Record Identification Number (RIN)	3	32	30
Filler (space filled)	33	293	261

Aging Category	Day Range
1	01-30 days
2	31-60 days
3	61-90 days*
4	91-120 days**
5	121 + days**

*Aging RINs in category '3' maybe subject to penalties/fines if they are not corrected by the next month's submission.
** Penalties/fines may be incurred on any erred record aging over 90 days.

EXAMPLES

1. Single error, resolved in March reconciliation

Erred Record Table	Submission Period	RIN	Record Type	Edits	EDS Process Date	Corrected Date	Aging Date	Aging Category
	January	11223344	O	0307	01/10/2000	Blank	02/01/2000	2
						03/25/2000		

Reconciliation processed on March 25. Edit 0307 resolved.

Accepted Record Table	Submission Period	RIN	Record Type	Edits	EDS Process date
	March	11223344	O		03/25/2000

2. Multiple errors, partially resolved in March reconciliation

Erred Record Table	Submission Period	RIN	Record Type	Edits	EDS Process Date	Corrected Date	Aging Date	Aging Category
	January	11223344	O	0208 0307	01/10/2000	Blank	02/01/2000	
						03/25/2000		2

Reconciliation processed on March 25. Edit 0307 resolved, edit 0208 remains. Original Aging Date retained.

	March	11223344	O	0208	03/25/2000	Blank	02/01/2000	2
						05/09/2000		4

May submission corrects the remaining 0208 edit.

Accepted Record Table	Submission Period	RIN	Record Type	Edits	EDS Process Date
	May	11223344	O		05/09/2000

Legend	
	Information not stored in any table
	Fields appended and populated during editing of record
	Field information provided by HMO

15.10.4 Accepted (A) RSR Record Section

The accepted record section shows records that have been recycled and accepted at EDS.

Field Name	Starting position	Ending position	Field size
RSR Record Designation (accepted record = A)	1	1	1
Encounter Type	2	2	1
HMO ID	3	10	8
Record Type	11	11	1
Record Identification Number (RIN)	12	41	30
HMO Process Date	42	49	8
Billing Provider NPI	50	59	10
Member ID	60	69	10
Assigned MSDRG	70	73	4
From Date of Service	74	81	8
Place of Service	82	83	2
HCPCS/NDC/Revenue Code	84	94	11
Modifier Code #1	95	96	2
Modifier Code #2	97	98	2
Quantity	99	107	9
ANSI/NCPDP code #1	108	109	3
ANSI/NCPDP code #2	110	113	3
ANSI/NCPDP code #3	114	116	3
ANSI/NCPDP code #4	117	119	3
Error Code Number	120	123	4
Explanation of Error Code	124	198	75
Record Error Type (C = Critical, N = Non-critical)	199	199	1
Field Number	200	201	2
Field Name	202	236	35
Value in Field That Erred	237	271	35
Group ID	**272**	**279**	**8**
Allowed Amount	**280**	**288**	**9**
Pricing Indicator	**289**	**293**	**5**

15.10.5 Erred (E) RSR Record Section

The erred record section shows records that have failed an error during processing and require correction by the HMO.

Field Name	Starting position	Ending position	Field size
RSR Record Designation (erred record = E)	1	1	1
Encounter Type	2	2	1
HMO ID	3	10	8
Record Type	11	11	1
Record Identification Number (RIN)	12	41	30
HMO Process Date	42	49	8
Billing Provider NPI	50	59	10
Member ID	60	69	10
DRG (removed, now filler)	70	72	3
From Date of Service	73	80	8
Place of Service	81	82	2
HCPCS/NDC/Revenue Code	83	93	11
Modifier Code #1	94	95	2
Modifier Code #2	96	97	2
Quantity	98	106	9
ANSI/NCPDP code #1	107	109	3
ANSI/NCPDP code #2	110	112	3
ANSI/NCPDP code #3	113	115	3
ANSI/NCPDP code #4	116	118	3
Error Code Number	119	122	4
Explanation of Error Code	123	197	75
Record Error Type (C = Critical, N = Non-critical)	198	198	1
Field Number	199	200	2
Field Name	201	235	35
Value in Field That Erred	236	270	35
Filler (space filled)	271	293	23

16 Electronic Correspondence

16.1 Overview

This section provides general guidelines for e-mail correspondence. Once a HMO has submitted a submission, all correspondence will be communicated through email. A matrix of situations where e-mail correspondences are required is provided below. Since e-mail will be the primary method of communication to the HMOs regarding their submission, a key aspect of this process is notifying the HMO Support group should e-mail or mail be returned undeliverable.

16.2 HMO Requirements

All HMOs must be able to send and receive e-mail from and to the HMO Support Group.

16.3 E-mail Notification Matrix

Event	HMO Contract Admin	HMO Technical Contact #1	HMO Technical Contact #2	HMO Technical Contact #3	DHCAA Contact	EDS HMO Support Group
Successful completions and reminders	Yes	Yes	If present	If present	Yes	Yes
Technical issues to be addressed by the HMO	No	Yes	If present	If present	No	Yes
Technical issues to be addressed by EDS	No	No	No	No	No	Yes

The HMO is only required to provide Contract Administrator information and Primary Technical Contact information. If an HMO provides additional technical contact information, the e-mail will be sent to that address as well.

17 National Code Sets

17.1 Overview

EDS maintains several sets of national codes for encounter validation purposes. HMO's are expected to update their code validation sets within a reasonable period of time after national implementation.

17.2 ICD9 Codes

ICD9 diagnosis codes and surgical procedure codes are updated annually, effective October 1 of the year they are issued. The State purchases the latest set of codes in a zipped text document from the CMS,. Diagnosis code 365 identifies Glaucoma. However, ICD9 requires that fourth and fifth digits be specified such as 365.04 – Ocular Hypertension. Therefore "365" is not loaded, "36504" is loaded. Any encounters specifying "365" for any of the diagnosis code fields will incur a critical edit failure. The CMS website that is used is: http://www.cms.hhs.gov/paymentsystems/icd9/

17.3 DRG Codes

Effective with the implementation of interChange, assigned DRG values will posted on the SSR report.

17.4 Procedure and Modifier Codes

HCPCS and CPT procedure code and modifier national code sets are updated annually in October and contain national begin and end dates. Currently these are loaded and updated in January. HMo Encounter edits against the national code table and the
Locally (State) defined codes are all end dated on 10/15/2003.

17.5 Revenue Codes

Revenue codes are updated nationally on a sporadic basis by the National Uniform Billing Committee (NUBC). Begin dates and end dates for codes are specified in the UB-04 form description, available to committee members. Similar information is also available directly from CMS. The State will monitor the CMS website for revenue code updates, and EDS will update the code set as the need is identified.

Locally (State) defined codes and all 3-digit versions of national codes are all end dated on 10/15/2003.

17.6 ANSI Codes (Claim Adjustment Reason Codes)

Claim Adjustment Reason Codes are updated quarterly. New codes are analyzed by DHCAA for appropriate setting for correction required, utilization, and financial use indicators. These preliminary decisions are then e-mailed to the HMOs for their feedback. Once this feedback has been discussed and approved by DHCAA the codes are loaded by EDS.

17.7 NCPDP Reject Codes

NCPDP Reject codes are available from the NCPDP website with a paid subscription. EDS updates the codes as the need arises – typically once per year. No begin or end dates are loaded.

17.8 National Drug Codes (NDC)

National Drug Codes are updated on a semi-monthly basis using the National Drug Data File from First Data Bank. Market date is used for the begin date, and Termination date is used for the end date.

Appendix A – Data Dictionary

Header Record

Field Name: **HMO ID** ***Field Number:*** 901

Description: Eight digit certified ForwardHealth provider number assigned to HMO (69xxxxxx).

DHCAA Required: Required ***Data Type:*** Alpha/Numeric ***Size:*** 8 ***Position:*** 1 -8

Applicability:

Edit #	*Type*	*Edit Description*
9003	Critical	Header record HMO ID does not match file name
9005	Critical	Header record HMO ID missing

Field Name: **Submission Date** ***Field Number:*** 902

Description: The date the submission was generated at the HMO (MMDDYYYY).

DHCAA Required: Required ***Data Type:*** Date ***Size:*** 8 ***Position:*** 9 -16

Applicability:

Edit #	*Type*	*Edit Description*
9007	Critical	Header submission date missing/invalid
9009	Critical	Header submission date must be <= EDS received date

Field Name: **Beginning Process Date** ***Field Number:*** 903

Description: The beginning process date used to extract encounter records for the submission (MMDDYYYY).

DHCAA Required: Required ***Data Type:*** Date ***Size:*** 8 ***Position:*** 17 -24

Applicability:

Edit #	*Type*	*Edit Description*
9010	Critical	Header beginning process date missing/invalid
9012	Critical	Header beginning process date must be < submission date
9013	Critical	Header beginning process date must be < ending process date

Header Record

Field Name: **Ending Process Date** ***Field Number:*** 904

Description: The ending process date used to extract encounter records for the submission (MMDDYYYY).

DHCAA Required: Required ***Data Type:*** Date ***Size:*** 8 ***Position:*** 25 -32

Applicability:

Edit #	*Type*	*Edit Description*
9015	Critical	Header ending process date missing/invalid
9017	Critical	Header ending process date must be <= submission date

Field Name: **Number of Records Transmitted** ***Field Number:*** 905

Description: The total number of records that are contained within the submission.

DHCAA Required: Required ***Data Type:*** Numeric ***Size:*** 8 ***Position:*** 33 -40

Applicability:

Edit #	*Type*	*Edit Description*
9020	Critical	Header Number of records transmitted missing/invalid
9022	Critical	Number of records transmitted not equal to header record value

Field Name: **HMO Contract Administrator Last Name** ***Field Number:*** 906

Description: HMO-designated contract administrator identified through ForwardHealth HMO contract process.

DHCAA Required: Required ***Data Type:*** Alpha/Numeric ***Size:*** 35 ***Position:*** 41 -75

Applicability:

Edit #	*Type*	*Edit Description*
None		

Field Name: **HMO Contract Administrator First Name** ***Field Number:*** 907

Description: HMO-designated contract administrator identified through ForwardHealth HMO contract process.

DHCAA Required: Required ***Data Type:*** Alpha/Numeric ***Size:*** 25 ***Position:*** 76 -100

Applicability:

Edit #	*Type*	*Edit Description*
None		

Field Name: **HMO Contract Administrator Email** ***Field Number:*** 908

Description: Address used to email information regarding submissions and meetings.

DHCAA Required: Required ***Data Type:*** Alpha/Numeric ***Size:*** 50 ***Position:*** 101 -150

Applicability:

Edit #	*Type*	*Edit Description*
None		

Header Record

Field Name: **HMO Technical Contact #1 Last Name** ***Field Number:*** 909
Description: HMO-designated primary contact for questions regarding the monthly submission and to receive confirmation of submission and the SSR

DHCAA Required: Required ***Data Type:*** Alpha/Numeric ***Size:*** 35 ***Position:*** 151 - 185
Applicability:

Edit #	*Type*	*Edit Description*
None		

Field Name: **HMO Technical Contact #1 First Name** ***Field Number:*** 910
Description: HMO-designated primary contact for questions regarding the monthly submission and to receive confirmation of submission and the SSR.

DHCAA Required: Required ***Data Type:*** Alpha/Numeric ***Size:*** 25 ***Position:*** 186 - 210
Applicability:

Edit #	*Type*	*Edit Description*
None		

Field Name: **HMO Technical Contact #1 Email** ***Field Number:*** 911
Description: Address used to email information regarding submissions and meetings.

DHCAA Required: Required ***Data Type:*** Alpha/Numeric ***Size:*** 50 ***Position:*** 211 - 260
Applicability:

Edit #	*Type*	*Edit Description*
None		

Field Name: **HMO Technical Contact #2 Last Name** ***Field Number:*** 912
Description: Additional person designated by the HMO to receive notification of submission and the SSR.

DHCAA Required: Optional ***Data Type:*** Alpha/Numeric ***Size:*** 35 ***Position:*** 261 - 295
Applicability:

Edit #	*Type*	*Edit Description*
None		

Header Record

Field Name: **HMO Technical Contact #2 First Name** ***Field Number:*** 913

Description: Additional person designated by the HMO to receive notification of submission and the SSR.

DHCAA Required: Optional ***Data Type:*** Alpha/Numeric ***Size:*** 25 ***Position:*** 296 -320

Applicability:

Edit #	*Type*	*Edit Description*
None		

Field Name: **HMO Technical Contact #2 Email** ***Field Number:*** 914

Description: Address used to email information regarding submissions and meetings.

DHCAA Required: Optional ***Data Type:*** Alpha/Numeric ***Size:*** 50 ***Position:*** 321 -370

Applicability:

Edit #	*Type*	*Edit Description*
None		

Field Name: **HMO Technical Contact #3 Last Name** ***Field Number:*** 915

Description: Additional person designated by the HMO to receive notification of submission and the SSR.

DHCAA Required: Optional ***Data Type:*** Alpha/Numeric ***Size:*** 35 ***Position:*** 371 -405

Applicability:

Edit #	*Type*	*Edit Description*
None		

Field Name: **HMO Technical Contact #3 First Name** ***Field Number:*** 916

Description: Additional person designated by the HMO to receive notification of submission and the SSR.

DHCAA Required: Optional ***Data Type:*** Alpha/Numeric ***Size:*** 25 ***Position:*** 406 -430

Applicability:

Edit #	*Type*	*Edit Description*
None		

Field Name: **HMO Technical Contact #3 Email** ***Field Number:*** 917

Description: Address used to email information regarding submissions and meetings.

DHCAA Required: Optional ***Data Type:*** Alpha/Numeric ***Size:*** 50 ***Position:*** 431 -480

Applicability:

Edit #	*Type*	*Edit Description*
None		

Header Record

Field Name: **Filler** ***Field Number:*** 918

Description: Filler

DHCAA Required: ***Data Type:*** Alpha/Numeric ***Size:*** 241 ***Position:*** 481 -722

Applicability:

Edit #	*Type*	*Edit Description*
None		

Detail Record

Field Name: **Encounter Type** ***Field Number:*** 1
Description: Identifies the encounter type as "dental", "inpatient", "outpatient hospital", "medical", or "pharmacy" based on encounter information being reported.

DHCAA Required: Required ***Data Type:*** Alpha ***Size:*** 1 ***Position:*** 1 -1

Applicability:

Edit #	*Type*	*Edit Description*
0824	Critical	Pharmacy records are not accepted for fill dates => 02/01/2008
1701	Critical	Encounter type required for all detail records
1702	Critical	Encounter type not on file

Field Name: **HMO ID** ***Field Number:*** 2
Description: Eight digit certified ForwardHealth provider number assigned to HMO (69xxxxxx).

DHCAA Required: Required ***Data Type:*** Numeric ***Size:*** 8 ***Position:*** 2 -9

Applicability:

Edit #	*Type*	*Edit Description*
0701	Critical	HMO ID missing
0702	Critical	HMO ID does not match HMO ID in File name

Field Name: **Data Source** ***Field Number:*** 3
Description: Identifies the source of data 1="claim/encounter" , 2="medical records", 3="other" (i.e. public health clinic).

DHCAA Required: Required ***Data Type:*** Numeric ***Size:*** 1 ***Position:*** 10 -10

Applicability:

Edit #	*Type*	*Edit Description*
1704	Critical	Data source not on file
1708	Critical	Data source required for all encounter types

Field Name: **Record Type** ***Field Number:*** 4
Description: O=Original (defined as the first time an encounter record is submitted) R=Reversal (defined as a reversal or deletion of the original encounter record; it negates the original record).

DHCAA Required: Required ***Data Type:*** Alpha ***Size:*** 1 ***Position:*** 11 -11

Applicability:

Edit #	*Type*	*Edit Description*
0703	Critical	Record Type missing
0705	Critical	Record type invalid

Detail Record

Field Name: **Record Identification Number** ***Field Number:*** 5

Description: Number assigned by the HMO to uniquely identify the record. This number is used for tracking purposes on error reports and is referenced when submitting a correction.

DHCAA Required: Required ***Data Type:*** Alpha/Numeric ***Size:*** 30 ***Position:*** 12 -41

Applicability:

Edit #	*Type*	*Edit Description*
0708	Critical	RIN is missing
0709	Critical	Reversal RIN does not have an original to reverse

Field Name: **Process Date** ***Field Number:*** 6

Description: Date the encounter was processed at the HMO.

DHCAA Required: Required ***Data Type:*** Date ***Size:*** 8 ***Position:*** 42 -49

Applicability:

Edit #	*Type*	*Edit Description*
0704	Critical	Required fields missing for Reversal record type
1710	Critical	Process date must be <= submission date
1711	Critical	Process date required for all encounter types
1712	Critical	Process Date invalid

Field Name: **Billing Provider NPI** ***Field Number:*** 7

Description: National Provider Identifier, converted Medicaid ID or interChange assigned ID for the individual, group, clinic, pharmacy, organization, etc. (Do not enter a billing service number in this field). IDs composed of 10 characters are considered NPIs. IDs less than 10 characters are considered ForwardHealth IDs. ForwardHealth IDs can be either 8 or 9 digits (8 is a converted Medicaid ID, 9 is for interChange-assigned IDs for non-medical providers). Provider IDs that are less than 10 digits must be right justified and blank filled.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 10 ***Position:*** 50 -59

Applicability: Data element is required if "Encounter Type" is "Inpatient", or if data source is 1 and Performing Provider NPI is blank or invalid.

Edit #	*Type*	*Edit Description*
0201	Non-critical	Billing provider not certified on date of service
0202	Critical	Billing Provider required for enc type I or O or Perf ID null and data scr = 1
0203	Critical	Billing provider cannot be HMO base payee ID
0204	Critical	Billing provider not on file
0207	Critical	Billing provider cannot be a billing service
0216	Critical	Billing provider must be in the hospital or nursing home ID range for ET=I

Field Name: **Billing Provider Name** ***Field Number:*** 8

Description: Name of individual/group/clinic/pharmacy/organization, etc.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 35 ***Position:*** 60 -94

Applicability: Data element is required if data source is 1 and billing provider ID is not blank.

Edit #	*Type*	*Edit Description*
0206	Critical	Billing provider name required if Billing provider id exists

Detail Record

Field Name: **Billing Provider Taxonomy** ***Field Number:*** 7

Description: Ten digit taxonomy code for the billing provider.

DHCAA Required: Required, if applicable ***Data Type:*** Numeric ***Size:*** 10 ***Position:*** 95 -104

Applicability:

Edit #	*Type*	*Edit Description*
0217	Critical	Valid billing provider taxonomy and zip code required for NPI
0218	Critical	Valid billing provider taxonomy required for NPI

Field Name: **Billing Provider ZIP+4** ***Field Number:*** 7

Description: Nine digit billing provider zip code.

DHCAA Required: Required, if applicable ***Data Type:*** Numeric ***Size:*** 9 ***Position:*** 105 -113

Applicability:

Edit #	*Type*	*Edit Description*
0217	Critical	Valid billing provider taxonomy and zip code required for NPI
0219	Critical	Valid billing provider zip code required for NPI

Detail Record

Field Name: **Member ID** ***Field Number:*** 9

Description: Member's ten digit ForwardHealth identification number.

DHCAA Required: Required ***Data Type:*** Numeric ***Size:*** 10 ***Position:*** 114 - 123

Applicability:

Edit #	*Type*	*Edit Description*
0101	Critical	Member ID not on file
0102	Non-critical	Member not enrolled in HMO on date of service
0103	Critical	Member ID missing
0104	Non-critical	Member not eligible on date of service
0108	Non-critical	Proc/Diag code indicates delivery, but enrollee file shows male gender
0109	Non-critical	Proc/Diag code indicates delivery, but enrollee file shows age <10 or >55

Field Name: **Member Last Name** ***Field Number:*** 10

Description: Last name of member exactly as it appears on the current ForwardHealth identification card.

DHCAA Required: Required ***Data Type:*** Alpha/Numeric ***Size:*** 35 ***Position:*** 124- 158

Applicability:

Edit #	*Type*	*Edit Description*
0105	Critical	Member last name missing
0106	Non-critical	First 5 characters of last name do not match name on file

Field Name: **Member First Name** ***Field Number:*** 11

Description: First name of member exactly as it appears on the current ForwardHealth identification card.

DHCAA Required: Required ***Data Type:*** Alpha/Numeric ***Size:*** 25 ***Position:*** 159- 183

Applicability:

Edit #	*Type*	*Edit Description*
0107	Critical	Member first name missing

Detail Record

Field Name: **Member Middle Initial** ***Field Number:*** 12

Description: Middle initial of member.

DHCAA Required: Optional ***Data Type:*** Alpha/Numeric ***Size:*** 1 ***Position:*** 184 - 184

Applicability:

Edit #	*Type*	*Edit Description*
None		

Field Name: **Other Provider** ***Field Number:*** 13

Description: Name or number of physician who performed a procedure listed on the encounter.

DHCAA Required: Optional ***Data Type:*** Alpha/Numeric ***Size:*** 35 ***Position:*** 185 - 219

Applicability:

Edit #	*Type*	*Edit Description*
None		

Field Name: **Attending Physician** ***Field Number:*** 14

Description: Name or number of physician who maintains primary responsibility for determining the patient's continued need for acute care and readiness for discharge, even when this physician has referred the patient to one or more consulting physicians.

DHCAA Required: Optional ***Data Type:*** Alpha/Numeric ***Size:*** 35 ***Position:*** 220 - 254

Applicability:

Edit #	*Type*	*Edit Description*
None		

Field Name: **Referring Provider NPI** ***Field Number:*** 15

Description: National Provider Identifier, converted Medicaid ID or interChange assigned ID for the individual, group, clinic, pharmacy, organization, etc. (Do not enter a billing service number in this field) of the certified physician referring member for care. IDs composed of 10 characters are considered NPIs. IDs less than 10 characters are considered ForwardHealth IDs. ForwardHealth IDs can be either 8 or 9 digits (8 is a converted Medicaid ID, 9 is for interChange-assigned IDs for non-medical providers). Provider IDs that are less than 10 digits must be right justified and blank filled.

DHCAA Required: Optional ***Data Type:*** Alpha/Numeric ***Size:*** 10 ***Position:*** 255 - 2641

Applicability:

Edit #	*Type*	*Edit Description*
None		

Field Name: **Facility Name or Number** ***Field Number:*** 16

Description: If member is a resident of an institution, or the encounter took place at a public health clinic, include the name or NPI of the institution/facility.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 35 ***Position:*** 265 - 299

Applicability: Data element is required for data source 2 and 3 if billing and performing provider information is unavailable.

Edit #	*Type*	*Edit Description*
0215	Critical	Facility name/ID required if Data Source = 2,3 and Bill/Perf ID = blank

Detail Record

Field Name: **Principal Diagnosis Code** ***Field Number:*** 17

Description: The full ICD-9 code describing the principal diagnosis (I.e. the condition established after study to be chiefly responsible for causing the admission or other health care episode).

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 8 ***Position:*** 300 -307

Applicability: Data element is required if "Encounter Type" is "Inpatient", "Outpatient" or "Medical" . FDOS for this encounter must be between the official Begin Date and End Date for this code.

Edit #	*Type*	*Edit Description*
0401	Critical	Principle Diagnosis code is required for encounter type I, O, and M
0418	Critical	E-diagnosis codes cannot be used as principle diagnosis
0419	Critical	Principle Diagnosis code not on file

Field Name: **Diagnosis Code #2** ***Field Number:*** 18

Description: Additional ICD-9 code for conditions that may coexist at the time services were rendered.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 8 ***Position:*** 308 -315

Applicability: Data element is required if additional codes are available. FDOS for this encounter must be between the official Begin Date and End Date for this code.

Edit #	*Type*	*Edit Description*
0402	Critical	2nd Diagnosis code not on file
0403	Critical	2nd Diagnosis code present with no principle diagnosis code

Field Name: **Diagnosis Code #3** ***Field Number:*** 19

Description: Additional ICD-9 code for conditions that may coexist at the time services were rendered.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 8 ***Position:*** 316 -323

Applicability: Data element is required if additional codes are available. FDOS for this encounter must be between the official Begin Date and End Date for this code.

Edit #	*Type*	*Edit Description*
0404	Critical	3rd Diagnosis code not on file
0405	Critical	3rd Diagnosis code present with no 2nd diagnosis code

Field Name: **Diagnosis Code #4** ***Field Number:*** 20

Description: Additional ICD-9 code for conditions that may coexist at the time services were rendered.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 8 ***Position:*** 324 -331

Applicability: Data element is required if additional codes are available. FDOS for this encounter must be between the official Begin Date and End Date for this code.

Edit #	*Type*	*Edit Description*
0406	Critical	4th Diagnosis code not on file
0407	Critical	4th Diagnosis code present with no 3rd diagnosis code

Detail Record

Field Name: **Diagnosis Code #5** ***Field Number:*** 21

Description: Additional ICD-9 code for conditions that may coexist at the time services were rendered.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 8 ***Position:*** 332 -339
Applicability: Data element is required if additional codes are available. FDOS for this encounter must be between the official Begin Date and End Date for this code.

Edit #	*Type*	*Edit Description*
0408	Critical	5th Diagnosis code not on file
0409	Critical	5th Diagnosis code present with no 4th diagnosis code

Field Name: **Diagnosis Code #6** ***Field Number:*** 22

Description: Additional ICD-9 code for conditions that may coexist at the time services were rendered.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 8 ***Position:*** 340 -347
Applicability: Data element is required if additional codes are available. FDOS for this encounter must be between the official Begin Date and End Date for this code.

Edit #	*Type*	*Edit Description*
0410	Critical	6th Diagnosis code not on file
0411	Critical	6th Diagnosis code present with no 5th diagnosis code

Field Name: **Diagnosis Code #7** ***Field Number:*** 23

Description: Additional ICD-9 code for conditions that may coexist at the time services were rendered.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 8 ***Position:*** 348 -355
Applicability: Data element is required if additional codes are available. FDOS for this encounter must be between the official Begin Date and End Date for this code.

Edit #	*Type*	*Edit Description*
0412	Critical	7th Diagnosis code not on file
0413	Critical	7th Diagnosis code present with no 6th diagnosis code

Field Name: **Diagnosis Code #8** ***Field Number:*** 24

Description: Additional ICD-9 code for conditions that may coexist at the time services were rendered.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 8 ***Position:*** 356 -371
Applicability: Data element is required if additional codes are available. FDOS for this encounter must be between the official Begin Date and End Date for this code.

Edit #	*Type*	*Edit Description*
0414	Critical	8th Diagnosis code not on file
0415	Critical	8th Diagnosis code present with no 7th diagnosis code

Detail Record

Field Name: **Diagnosis Code #9** ***Field Number:*** 25

Description: Additional ICD-9 code for conditions that may coexist at the time services were rendered.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 8 ***Position:*** 364 -371

Applicability: Data element is required if additional codes are available. FDOS for this encounter must be between the official Begin Date and End Date for this code.

Edit #	*Type*	*Edit Description*
0416	Critical	9th Diagnosis code not on file
0417	Critical	9th Diagnosis code present with no 8th diagnosis code

Field Name: **Diagnosis Code #10** ***Field Number:*** 25

Description: Additional ICD-9 code for conditions that may coexist at the time services were rendered.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 8 ***Position:*** 373 -379

Applicability: Data element is required if additional codes are available. FDOS for this encounter must be between the official Begin Date and End Date for this code.

Edit #	*Type*	*Edit Description*
0420	Critical	10th Diagnosis code not on file
0421	Critical	10th Diagnosis code present with no 9th diagnosis code

Field Name: **Diagnosis Code #11** ***Field Number:*** 25

Description: Additional ICD-9 code for conditions that may coexist at the time services were rendered.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 8 ***Position:*** 380 -387

Applicability: Data element is required if additional codes are available. FDOS for this encounter must be between the official Begin Date and End Date for this code.

Edit #	*Type*	*Edit Description*
0422	Critical	11th Diagnosis code not on file
0423	Critical	11th Diagnosis code present with no 10th diagnosis code

Field Name: **Diagnosis Code #12** ***Field Number:*** 25

Description: Additional ICD-9 code for conditions that may coexist at the time services were rendered.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 8 ***Position:*** 388 -395

Applicability: Data element is required if additional codes are available. FDOS for this encounter must be between the official Begin Date and End Date for this code.

Edit #	*Type*	*Edit Description*
0424	Critical	12th Diagnosis code not on file
0425	Critical	12th Diagnosis code present with no 11th diagnosis code

Field Name: **Diagnosis Code #13** ***Field Number:*** 25

Description: Additional ICD-9 code for conditions that may coexist at the time services were rendered.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 8 ***Position:*** 396 -403

Applicability: Data element is required if additional codes are available. FDOS for this encounter must be between the official Begin Date and End Date for this code.

Edit #	*Type*	*Edit Description*

0426	Critical	13th Diagnosis code not on file
0427	Critical	13th Diagnosis code present with no 12th diagnosis code

Field Name: **Diagnosis Code #14** ***Field Number:*** 25

Description: Additional ICD-9 code for conditions that may coexist at the time services were rendered.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 8 ***Position:*** 404 -411

Applicability: Data element is required if additional codes are available. FDOS for this encounter must be between the official Begin Date and End Date for this code.

Edit #	*Type*	*Edit Description*
0428	Critical	14th Diagnosis code not on file
0429	Critical	14th Diagnosis code present with no 13th diagnosis code

Field Name: **Diagnosis Code #15** ***Field Number:*** 25

Description: Additional ICD-9 code for conditions that may coexist at the time services were rendered.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 8 ***Position:*** 412 -419

Applicability: Data element is required if additional codes are available. FDOS for this encounter must be between the official Begin Date and End Date for this code.

Edit #	*Type*	*Edit Description*
0430	Critical	15th Diagnosis code not on file
0431	Critical	15th Diagnosis code present with no 14th diagnosis code

Field Name: **Diagnosis Code #16** ***Field Number:*** 25

Description: Additional ICD-9 code for conditions that may coexist at the time services were rendered.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 8 ***Position:*** 420 -427

Applicability: Data element is required if additional codes are available. FDOS for this encounter must be between the official Begin Date and End Date for this code.

Edit #	*Type*	*Edit Description*
0431	Critical	16th Diagnosis code not on file
0432	Critical	16th Diagnosis code present with no 15th diagnosis code

Field Name: **Diagnosis Code #17** ***Field Number:*** 25

Description: Additional ICD-9 code for conditions that may coexist at the time services were rendered.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 8 ***Position:*** 428 -435

Applicability: Data element is required if additional codes are available. FDOS for this encounter must be between the official Begin Date and End Date for this code.

Edit #	*Type*	*Edit Description*
0433	Critical	17th Diagnosis code not on file
0434	Critical	17th Diagnosis code present with no 16th diagnosis code

Field Name: **Diagnosis Code #18** ***Field Number:*** 25

Description: Additional ICD-9 code for conditions that may coexist at the time services were rendered.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 8 ***Position:*** 436 443

Applicability: Data element is required if additional codes are available. FDOS for this encounter must be between the official Begin Date and End Date for this code.

Edit #	Type	Edit Description
0435	Critical	18th Diagnosis code not on file
0436	Critical	18th Diagnosis code present with no 17th diagnosis code

Field Name: **DX Version Indicator** ***Field Number:*** 103

Description: Diagnosis and Procedure code Qualifier (ICD Version Indicator)Required. The qualifier that denotes the version of International Classification of Diseases (ICD) reported. The following qualifier codes reflect the edition portion of the ICD: 9 - Ninth Revision, 0 - Tenth Revision. Medicare does not accept ICD-10 codes. Medicare only processes ICD-9 codes.

DHCAA Required: ***Data Type:*** Alpha/Numeric ***Size:*** 1 ***Position:*** 444 -444

Applicability:

Edit #	Type	Edit Description

Field Name: **Admission Diagnosis Code** ***Field Number:*** 26

Description: The ICD-9 diagnosis code provided at the time of admission as stated by the physician.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 6 ***Position:*** 445 -485

Applicability: Data element is required if "Encounter Type" equals "Inpatient". FDOS for this encounter must be between the official Begin Date and End Date for this code.

Edit #	Type	Edit Description
0501	Critical	Admission diagnosis not on file
0502	Critical	Admission diagnosis required when encounter type is Inpatient

Field Name: **ICD Procedure Code #1** ***Field Number:*** 28

Description: The code that identifies the principle procedure performed during the period covered by this encounter.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 5 ***Position:*** 453 -457

Applicability: Data element is required if surgery has been performed. FDOS for this encounter must be between the official Begin Date and End Date for this code.

Edit #	Type	Edit Description
0503	Critical	Principle ICD procedure code not on file

Detail Record

Field Name: **ICD Procedure Code #2** ***Field Number:*** 29

Description: The code that identifies additional procedures performed during the period covered by this encounter.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 5 ***Position:*** 458 -462

Applicability: Data element is required if available. FDOS for this encounter must be between the official Begin Date and End Date for this code.

Edit #	*Type*	*Edit Description*
0504	Critical	First other ICD procedure code not on file

Field Name: **ICD Procedure Code #3** ***Field Number:*** 30

Description: The code that identifies additional procedures performed during the period covered by this encounter.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 5 ***Position:*** 463 -467

Applicability: Data element is required if available. FDOS for this encounter must be between the official Begin Date and End Date for this code.

Edit #	*Type*	*Edit Description*
0505	Critical	Second other ICD procedure code not on file

Field Name: **ICD Procedure Code #4** ***Field Number:*** 31

Description: The code that identifies additional procedures performed during the period covered by this encounter.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 5 ***Position:*** 468 -472

Applicability: Data element is required if available. FDOS for this encounter must be between the official Begin Date and End Date for this code.

Edit #	*Type*	*Edit Description*
0506	Critical	Third other ICD procedure code not on file

Field Name: **ICD Procedure Code #5** ***Field Number:*** 32

Description: The code that identifies additional procedures performed during the period covered by this encounter.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 5 ***Position:*** 473 -477

Applicability: Data element is required if available. FDOS for this encounter must be between the official Begin Date and End Date for this code.

Edit #	*Type*	*Edit Description*
0507	Critical	Fourth other ICD procedure code not on file

Detail Record

Field Name: **ICD Procedure Code #6** ***Field Number:*** 33

Description: The code that identifies additional procedures performed during the period covered by this encounter.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 5 ***Position:*** 478 -482

Applicability: Data element is required if available. FDOS for this encounter must be between the official Begin Date and End Date for this code.

Edit #	*Type*	*Edit Description*
0508	Critical	Fifth other ICD procedure code not on file

Field Name: **Admission Type** ***Field Number:*** 34

Description: A code indicating the priority of this admission: "1=emergency", "2=urgent", "3=elective", or "4=newborn".

DHCAA Required: Required, if applicable ***Data Type:*** Numeric ***Size:*** 1 ***Position:*** 483 -483

Applicability: Data element is required if "Encounter Type" equals "Inpatient".

Edit #	*Type*	*Edit Description*
0509	Critical	Admission type not on file

Field Name: **Admission Source** ***Field Number:*** 35

Description: A code indicating the source of this admission. (I.e. Physician or clinic referral, transfer from nursing home facility, etc. See UB-04 manual for coding structure).

DHCAA Required: Optional ***Data Type:*** Alpha/Numeric ***Size:*** 1 ***Position:*** 484 -484

Applicability:

Edit #	*Type*	*Edit Description*
0511	Critical	Admission source not on file

Field Name: **Patient Status Code** ***Field Number:*** 36

Description: A code indicating patient status as of the through date of service. (I.e. Discharged to home or self care, Discharged/transferred to skilled nursing facility, etc. See UB-04 Manual for coding structure).

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 2 ***Position:*** 485 -486

Applicability: Data element is required if "Encounter Type" equals "Inpatient".

Edit #	*Type*	*Edit Description*
0512	Critical	Patient status code not on file
0513	Critical	Patient status code required when encounter type is Inpatient

Detail Record

Field Name: **Admission Date** ***Field Number:*** 37

Description: The date the patient was admitted to the provider for inpatient care, outpatient service or start of care.

DHCAA Required: Required, if applicable ***Data Type:*** Date ***Size:*** 8 ***Position:*** 487 -494

Applicability: Data element is required if "Encounter Type" equals "Inpatient".

Edit #	*Type*	*Edit Description*
0514	Critical	Admission date required when encounter type is Inpatient
0515	Critical	Admission Date invalid
0516	Critical	Admission date must be <= submission date
0517	Critical	Admission date must be <= from date of service

Field Name: **Value Code #1** ***Field Number:*** 38

Description: A code used to relate values to identified data elements necessary to process this encounter.

DHCAA Required: Optional ***Data Type:*** Alpha/Numeric ***Size:*** 2 ***Position:*** 495 -496

Applicability:

Edit #	*Type*	*Edit Description*
0518	Critical	Value code 1 not on file

Field Name: **Value Amount #1** ***Field Number:*** 39

Description: A code used to relate amounts to identified data elements necessary to process this encounter.

DHCAA Required: Optional ***Data Type:*** Numeric ***Size:*** 7 ***Position:*** 497 -503

Applicability:

Edit #	*Type*	*Edit Description*
0519	Critical	Value amount 1 must be >0 and value code 1 required unless code = 02 or 45

Field Name: **Value Code #2** ***Field Number:*** 40

Description: A code used to relate values to identified data elements necessary to process this encounter.

DHCAA Required: Optional ***Data Type:*** Alpha/Numeric ***Size:*** 2 ***Position:*** 504 -505

Applicability:

Edit #	*Type*	*Edit Description*
0520	Critical	Value code 2 not on file

Detail Record

Field Name: **Value Amount #2** ***Field Number:*** 41

Description: A code used to relate amounts to identified data elements necessary to process this encounter.

DHCAA Required: Optional ***Data Type:*** Numeric ***Size:*** 7 ***Position:*** 506 -512

Applicability:

Edit #	*Type*	*Edit Description*
0521	Critical	Value amount 2 must be >0 and value code 2 required unless code = 02 or 45

Field Name: **Value Code #3** ***Field Number:*** 42

Description: A code used to relate values to identified data elements necessary to process this encounter.

DHCAA Required: Optional ***Data Type:*** Alpha/Numeric ***Size:*** 2 ***Position:*** 543 -514

Applicability:

Edit #	*Type*	*Edit Description*
0522	Critical	Value code 3 not on file

Field Name: **Value Amount #3** ***Field Number:*** 43

Description: A code used to relate amounts to identified data elements necessary to process this encounter.

DHCAA Required: Optional ***Data Type:*** Numeric ***Size:*** 7 ***Position:*** 515- 521

Applicability:

Edit #	*Type*	*Edit Description*
0523	Critical	Value amount 3 must be >0 and value code 3 required unless code = 02 or 45

Field Name: **Value Code #4** ***Field Number:*** 44

Description: A code used to relate values to identified data elements necessary to process this encounter.

DHCAA Required: Optional ***Data Type:*** Alpha/Numeric ***Size:*** 2 ***Position:*** 522 -523

Applicability:

Edit #	*Type*	*Edit Description*
0524	Critical	Value code 4 not on file

Field Name: **Value Amount #4** ***Field Number:*** 45

Description: A code used to relate amounts to identified data elements necessary to process this encounter.

DHCAA Required: Optional ***Data Type:*** Numeric ***Size:*** 7 ***Position:*** 524 -530

Applicability:

Edit #	*Type*	*Edit Description*
0525	Critical	Value amount 4 must be >0 and value code 4 required unless code = 02 or 45

Detail Record

Field Name: **From Date of Service** ***Field Number:*** 58

Description: First date of service.

DHCAA Required: Required, if applicable ***Data Type:*** Date ***Size:*** 8 ***Position:*** 531 - 538

Applicability: Required for all encounter types except pharmacy which uses prescription Fill Date.

Edit #	*Type*	*Edit Description*
0902	Critical	From date of service required if encounter type = I, D, O, M
0903	Critical	From Date of Service invalid
0904	Critical	From date of service must be <= submission date

Field Name: **To Date of Service** ***Field Number:*** 59

Description: Date of discharge or last date of bill.

DHCAA Required: Required, if applicable ***Data Type:*** Date ***Size:*** 8 ***Position:*** 539 - 546

Applicability: Data element is required if "Encounter Type" is "Inpatient".

Edit #	*Type*	*Edit Description*
0906	Critical	To date of service must be >= From date of service
0907	Critical	To date of service required if encounter type = I
0908	Critical	To Date of Service invalid
0909	Critical	To date of service must be <= submission date

Field Name: **Prescription Date** ***Field Number:*** 60

Description: The date the drug was prescribed.

DHCAA Required: Required, if applicable ***Data Type:*** Date ***Size:*** 8 ***Position:*** 547 - 554

Applicability: Data element is required if "Encounter Type" is "Pharmacy".

Edit #	*Type*	*Edit Description*
0801	Critical	Prescription (RX) Date is invalid
0802	Critical	Prescription date must be <= submission date
0804	Critical	Prescription date required for encounter type = P

Detail Record

Field Name: **Fill Date** ***Field Number:*** 61

Description: The date the prescription was filled.

DHCAA Required: Required, if applicable ***Data Type:*** Date ***Size:*** 8 ***Position:*** 555 - 562

Applicability: Data element is required if "Encounter Type" is "Pharmacy".

Edit #	*Type*	*Edit Description*
0803	Critical	Fill date must be within 367 days of the prescribed date
0805	Critical	Fill Date is invalid
0806	Critical	Fill date required for encounter type = P
0807	Critical	Fill date must be <= submission date
0808	Critical	Fill date must be >= prescription date

Field Name: **National Place of Service** ***Field Number:*** 62

Description: National Place of Service Code.

DHCAA Required: Required, if applicable ***Data Type:*** Numeric ***Size:*** 2 ***Position:*** 563 - 564

Applicability: Data element is required if "Encounter Type" is "Dental or Medical".

Edit #	*Type*	*Edit Description*
0301	Critical	Place of service required for encounter type M and D
0302	Critical	Place of service not on file

Field Name: **Procedure Code** ***Field Number:*** 64

Description: CPT or HCPCS code.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 5 ***Position:*** 565 - 569

Applicability: Data element is required if "Encounter Type" is "Dental". Also, it is required for "Medical", and Outpatient" "Encounter Type"s if revenue code is not present. FDOS for this encounter must be between the official Begin Date and End Date for this code.

Edit #	*Type*	*Edit Description*
0305	Critical	Proc code required if encounter type = M, I or O and Rev Code field = blank
0306	Critical	Proc code required if encounter type = D
0307	Critical	Procedure code not on file
0313	Critical	Procedure code required if data source = 2 or 3
0316	Non-critical	Procedure Code for DOS submitted is not in the national reference code set

Detail Record

Field Name: **Modifier Code #1** ***Field Number:*** 65

Description: Two digit modifier code.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 2 ***Position:*** 570 -571

Applicability: Data element is required if you have retained a modifier for the procedure code. FDOS for this encounter must be between the official Begin Date and End Date for this code.

Edit #	*Type*	*Edit Description*
0308	Critical	Mod 1 not on file; not part of HCPCS code set or Amb./Trans. code set

Field Name: **Modifier Code #2** ***Field Number:*** 66

Description: Additional two digit modifier code.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 2 ***Position:*** 572 -573

Applicability: Data element is required if you have retained a modifier for the procedure code. FDOS for this encounter
must be between the official Begin Date and End Date for this code.

Edit #	*Type*	*Edit Description*
0309	Critical	Mod 2 not on file; not part of HCPCS code set or Amb./Trans. code set

Field Name: **Modifier Code #3** ***Field Number:*** 87

Description: Additional two digit modifier code.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 2 ***Position:*** 574 -575

Applicability: Data element is required if you have retained a modifier for the procedure code. FDOS for this encounter must be between the official Begin Date and End Date for this code.

Edit #	*Type*	*Edit Description*
0314	Critical	Mod 4 not on file; not part of HCPCS code set or Amb./Trans. code set

Field Name: **Modifier Code #4** ***Field Number:*** 88

Description: Additional two digit modifier code.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 2 ***Position:*** 576 -577

Applicability: Data element is required if you have retained a modifier for the procedure code. FDOS for this encounter must be between the official Begin Date and End Date for this code.

Edit #	*Type*	*Edit Description*
0315	Critical	Mod 4 not on file; not part of HCPCS code set or Amb./Trans. code set

Field Name: **Revenue Code** ***Field Number:*** 67

Description: A code which identifies a specific accommodation, ancillary service or billing calculation.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 4 ***Position:*** 578 -581

Applicability: Data element is required if "Encounter Type" is "Inpatient". Also, it is required for "Medical" and "Outpatient" "Encounter Type"s if procedure code is not present.FDOS for this encounter must be between the official Begin Date and End Date for this code.

Edit #	*Type*	*Edit Description*
0310	Critical	Rev code required if encounter type M, I or O and Proc code = blank
0311	Critical	Revenue code not on file

Field Name: **NDC Code** ***Field Number:*** 68

Description: National Drug Code.

DHCAA Required: Required, if applicable ***Data Type:*** Numeric ***Size:*** 11 ***Position:*** 582 -592

Applicability: Data element is required if "Encounter Type" is "Pharmacy" .

Edit #	*Type*	*Edit Description*
0810	Non-critical	NDC not on file
0811	Critical	NDC required if encounter type = pharmacy
0822	Critical	NDC must be 11 digits and numeric for ET=(P) Pharmacy.
0823	Non-critical	NDC Fill Date not between the availabilty date and the expiration date

Detail Record

Field Name: **Quantity** ***Field Number:*** 69

Description: A quantitative measure of services rendered according to the encounter type.

DHCAA Required: Required ***Data Type:*** Numeric ***Size:*** 9 ***Position:*** 593 -601

Applicability:

Edit #	*Type*	*Edit Description*
1002	Critical	Quantity is required for record type = O
1003	Critical	Quantity must be > 0.009 for record type = O
1006	Non-critical	Quantity must be < or = to 1000 for encounter type P

Field Name: **Days Supply** ***Field Number:*** 70

Description: Estimated number of days the prescription will last.

DHCAA Required: Required, if applicable ***Data Type:*** Numeric ***Size:*** 3 ***Position:*** 602 -604

Applicability: Data element is required if "Encounter Type" is "Pharmacy" .

Edit #	*Type*	*Edit Description*
0812	Critical	Days supply required must be > 0 and < or = to 100 for encounter type P

Field Name: **Performing Provider NPI** ***Field Number:*** 71

Description: National Provider Identifier, converted Medicaid ID or interChange assigned ID for the individual, group, clinic, pharmacy, organization, etc. (Do not enter a billing service number in this field) of provider rendering or performing the service. IDs composed of 10 characters are considered NPIs. IDs less than 10 characters are considered ForwardHealth IDs. ForwardHealth IDs can be either 8 or 9 digits (8 is a converted Medicaid ID, 9 is for interChange-assigned IDs for non-medical providers). Provider IDs that are less than 10 digits must be right justified and blank filled.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 10 ***Position:*** 605- 614

Applicability: Data element is required if data source = 1 and billing provider ID is blank.

Edit #	*Type*	*Edit Description*
0208	Critical	Performing Provider NPI not on file
0209	Non-critical	Performing provider not certified on date of service
0210	Non-critical	Valid Performing or Billing Provider ID is required if data source = 1
0211	Critical	Performing Provider NPI cannot be HMO base payee ID

Field Name: **Performing Provider Name** ***Field Number:*** 72

Description: Name of provider rendering the service.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 35 ***Position:*** 615 -649

Applicability: Data element is required if data source = 1 and Performing Provider NPI is not blank.

Edit #	*Type*	*Edit Description*
0212	Critical	Performing provider name required if Performing Provider NPI exists

Field Name: **Performing Provider Taxonomy** ***Field Number:*** 92

Description: Ten-character performing provider taxonomy code..

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 10 ***Position:*** 650 -659

Applicability: Data element is required if data source = 1 and Performing Provider NPI is not blank.

Edit #	*Type*	*Edit Description*
0220	Critical	Valid performing provider taxonomy and zip code required for NPI
0221	Critical	Valid performing provider taxonomy required for NPI

Detail Record

Field Name: **Performing Provider ZIP +4** ***Field Number:*** 93

Description: Zip code of the performing provider.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 35 ***Position:*** 660 -668

Applicability: Data element is required if data source = 1 and Performing Provider NPI is not blank.

Edit #	*Type*	*Edit Description*
0220	Critical	Valid performing provider taxonomy and zip code required for NPI
0222	Critical	Valid performing provider zip code required for NPI

Field Name: **Prescriber DEA** ***Field Number:*** 73

Description: DEA of the prescribing provider.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 9 ***Position:*** 669 -678

Applicability: Data element is required if "Encounter Type" is "Pharmacy".

Edit #	*Type*	*Edit Description*
0813	Non-critical	Prescriber DEA not on file
0814	Critical	Prescriber DEA required if encounter type = Pharmacy

Field Name: **Prescription Number** ***Field Number:*** 74

Description: Unique prescription number.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 8 ***Position:*** 679 -686

Applicability: Data elements is required if "Encounter Type" is "Pharmacy".

Edit #	*Type*	*Edit Description*
0815	Critical	Prescription number required if encounter type = Pharmacy

Field Name: **Refill Indicator** ***Field Number:*** 75

Description: Indicates if drug is a new prescription or which refill number is being supplied.

DHCAA Required: Required, if applicable ***Data Type:*** Numeric ***Size:*** 2 ***Position:*** 687 -688

Applicability: Data elements is required if "Encounter Type" is "Pharmacy".

Edit #	*Type*	*Edit Description*
0817	Critical	Refill indicator required if encounter type = Pharmacy

Field Name: **Unit Dose** ***Field Number:*** 76

Description: Indicator used when billing unit dose drugs.

DHCAA Required: Required, if applicable ***Data Type:*** Numeric ***Size:*** 1 ***Position:*** 689 -689

Applicability: Data element is required when billing unit dose drugs.

Edit #	*Type*	*Edit Description*
0818	Critical	Unit dose value not on file
0820	Critical	Unit dose required for encounter type = P

Detail Record

Field Name: **DAW (Dispense as written)** ***Field Number:*** 77

Description: Indicator showing whether a brand name drug can be dispensed in lieu of a generic.

DHCAA Required: Required, if applicable ***Data Type:*** Numeric ***Size:*** 1 ***Position:*** 690 -690

Applicability: Data elements is required if "Encounter Type" is "Pharmacy".

Edit #	*Type*	*Edit Description*
0819	Critical	DAW value not on file
0821	Critical	DAW (dispensed as written) required for encounter type = P

Field Name: **Emergency Service Indicator** ***Field Number:*** 78

Description: Indicator showing if the service was an emergency. Values are Y=Yes, N=No, or U=Unknown.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha ***Size:*** 1 ***Position:*** 691 -691

Applicability: Data element is required if "Encounter Type" is "Medical".

Edit #	*Type*	*Edit Description*
1501	Critical	Emergency services indicator not on file
1502	Critical	Emergency indicator required for encounter type = M

Field Name: **HealthCheck Referral Indicator** ***Field Number:*** 79

Description: Indicator showing if services provided were a result of a screen and referral. Values are Y=Yes, N=No, or U=Unknown.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha ***Size:*** 1 ***Position:*** 692 692

Applicability: Data element is required if "Encounter Type" is "Dental or Medical".

Edit #	*Type*	*Edit Description*
1503	Critical	Healthcheck indicator not on file
1504	Critical	Healthcheck indicator required for encounter type = M or D

Field Name: **Family Planning Indicator** ***Field Number:*** 80

Description: Indicator showing whether Family Planning was involved when rendering the service. Values are Y=Yes, N=No, or U=Unknown.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha ***Size:*** 1 ***Position:*** 693 -693

Applicability: Data element is required if "Encounter Type" is "Medical".

Edit #	*Type*	*Edit Description*
1505	Critical	Family planning indicator not on file
1506	Critical	Family planning indicator required for encounter type = M

Detail Record

Field Name: **Financial Indicator** ***Field Number:*** 89

Description: Indicator showing whether the encounter was paid by the health plan. This indicator will override ANSI codes for pricing. Valid values - specifying "Y" means paid, or would have paid (and should be considered for costing), "N" means HMO did not pay and would not have paid. If this field is blank, the ANSI codes are looked at to determine a value.

DHCAA Required: Optional ***Data Type:*** Alpha ***Size:*** 1 ***Position:*** 694 -694

Applicability:

Edit #	*Type*	*Edit Description*
1507	Critical	Invalid financial indicator

Field Name: **Charges** ***Field Number:*** 81

Description: Total charges associated with service rendered.

DHCAA Required: Required ***Data Type:*** Numeric ***Size:*** 9 ***Position:*** 695 -703

Applicability:

Edit #	*Type*	*Edit Description*
1004	Critical	Charges are required for record type = O
1005	Non-critical	Charges must be > 0 for original record type unless cap or info encounter
1007	Non-critical	Charges are $0.00 for enc type = O

Field Name: **TPL Paid Amount** ***Field Number:*** 82

Description: Amount paid by third party insurer.

DHCAA Required: Required, if applicable ***Data Type:*** Numeric ***Size:*** 7 ***Position:*** 704 -710

Applicability: Data element is required if payment has been made by third party insurer.

Edit #	*Type*	*Edit Description*
None		

Field Name: **ANSI/NCPDP Code #1** ***Field Number:*** 83

Description: This element is required if the encounter has been denied. This field is used for ANSI codes on encounter types D, I, O, M. The field is used for NCPDP reject codes on Pharmacy encounters.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 3 ***Position:*** 711 -7137

Applicability: Data element is required if the encounter is based on a claim that has been denied.

Edit #	*Type*	*Edit Description*
1601	Critical	ANSI/NCPDP code 1 not on file

Field Name: **ANSI/NCPDP Code #2** ***Field Number:*** 84

Description: This element is required if the encounter has been denied. This field is used for ANSI codes on encounter types D, I, O, M. The field is used for NCPDP reject codes on Pharmacy encounters.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 3 ***Position:*** 714 -716

Applicability: Data element is required if the encounter is based on a claim that has additional denials.

Edit #	*Type*	*Edit Description*
1602	Critical	ANSI/NCPDP code 2 not on file

Detail Record

Field Name: **ANSI/NCPDP Code #3** ***Field Number:*** 85

Description: This element is required if the encounter has been denied. This field is used for ANSI codes on encounter types D, I, O, M. The field is used for NCPDP reject codes on Pharmacy encounters.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 3 ***Position:*** 717 -719

Applicability: Data element is required if the encounter is based on a claim that has additional denials.

Edit #	*Type*	*Edit Description*
1603	Critical	ANSI/NCPDP code 3 not on file

Field Name: **ANSI/NCPDP Code #4** ***Field Number:*** 86

Description: This element is required if the encounter has been denied. This field is used for ANSI codes on encounter types D, I, O, M. The field is used for NCPDP reject codes on Pharmacy encounters.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 3 ***Position:*** 720 -722

Applicability: Data element is required if the encounter is based on a claim that has additional denials.

Edit #	*Type*	*Edit Description*
1604	Critical	ANSI/NCPDP code 4 not on file

Field Name: **Modifier Code #3** ***Field Number:*** 87

Description: Additional two digit modifier code.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 2 ***Position:*** 461 -462

Applicability: Data element is required if you have retained a modifier for the procedure code. FDOS for this encounter must be between the official Begin Date and End Date for this code.

Edit #	*Type*	*Edit Description*
0314	Critical	Mod 3 not on file; not part of HCPCS code set or Amb./Trans. code set

Field Name: **Modifier Code #4** ***Field Number:*** 88

Description: Additional two digit modifier code.

DHCAA Required: Required, if applicable ***Data Type:*** Alpha/Numeric ***Size:*** 2 ***Position:*** 720 -722

Applicability: Data element is required if you have retained a modifier for the procedure code. FDOS for this encounter must be between the official Begin Date and End Date for this code.

Edit #	*Type*	*Edit Description*
0315	Critical	Mod 4 not on file; not part of HCPCS code set or Amb./Trans. code set

Field Name to Number Cross-Reference

Field Name	*Old Name*	*Field#*	*Location*
Admission Date		37	Detail Record
Admission Diagnosis Code		26	Detail Record
Admission Source		35	Detail Record
Admission Type		34	Detail Record
ANSI/NCPDP Code #1	ANSI/NCPDP Code 1	83	Detail Record
ANSI/NCPDP Code #2	ANSI/NCPDP Code 2	84	Detail Record
ANSI/NCPDP Code #3	ANSI/NCPDP Code 3	85	Detail Record
ANSI/NCPDP Code #4	ANSI/NCPDP Code 4	86	Detail Record
Attending Physician		14	Detail Record
Beginning Process Date		903	Header Record
Billing Provider NPI		7	Detail Record
Billing Provider Name		8	Detail Record
Charges		81	Detail Record
Data Source		3	Detail Record
DAW (Dispense as written)		77	Detail Record
Days Supply		70	Detail Record
Diagnosis Code #1	Principle Diagnosis Code	17	Detail Record
Diagnosis Code #2	Second Diagnosis Code	18	Detail Record
Diagnosis Code #3	Third Diagnosis Code	19	Detail Record
Diagnosis Code #4	Fourth Diagnosis Code	20	Detail Record
Diagnosis Code #5	Fifth Diagnosis Code	21	Detail Record
Diagnosis Code #6	Sixth Diagnosis Code	22	Detail Record
Diagnosis Code #7	Seventh Diagnosis Code	23	Detail Record
Diagnosis Code #8	Eighth Diagnosis Code	24	Detail Record
Diagnosis Code #9	Ninth Diagnosis Code	25	Detail Record
Diagnosis Code #10	Tenth Diagnosis Code	94	Detail Record
Diagnosis Code #11	Eleventh Diagnosis Code	95	Detail Record
Diagnosis Code #12	Twelth Diagnosis Code	96	Detail Record
Diagnosis Code #13	Thirteenth Diagnosis Code	97	Detail Record
Diagnosis Code #14	Fourthteenth Diagnosis Code	98	Detail Record
Diagnosis Code #15	Fifteenth Diagnosis Code	99	Detail Record
Diagnosis Code #16	Sixteenth Diagnosis Code	100	Detail Record
Diagnosis Code #17	Seventeenth Diagnosis Code	101	Detail Record
Diagnosis Code #18	Eighteenth Diagnosis Code	102	Detail Record
DxVersion Indicator	DX Version Indicator	103	Detail Record

Field Name to Number Cross-Reference

Field Name	*Old Name*	*Field#*	*Location*
Emergency Service Indicator		78	Detail Record
Encounter Type		1	Detail Record
Ending Process Date		904	Header Record
Facility Name or Number		16	Detail Record
Financial Indicator		89	Detail Record
Family Planning Indicator		80	Detail Record
Fill Date		61	Detail Record
Filler		918	Header Record
From Date of Service		58	Detail Record
HealthCheck Referral Indicator		79	Detail Record
HMO Contract Administrator Email		908	Header Record
HMO Contract Administrator First Name		907	Header Record
HMO Contract Administrator Last Name		906	Header Record
HMO ID		2	Detail Record
HMO ID		901	Header Record
HMO Technical Contact #1 Email	HMO Primary Technical Contact Email	911	Header Record
HMO Technical Contact #1 First Name	HMO Primary Technical Contact First Name	910	Header Record
HMO Technical Contact #1 Last Name	HMO Primary Technical Contact Last Name	909	Header Record
HMO Technical Contact #2 Email	HMO Second Technical Contact Email	914	Header Record
HMO Technical Contact #2 First Name	HMO Second Technical Contact First Name	913	Header Record
HMO Technical Contact #2 Last Name	HMO Second Technical Contact Last Name	912	Header Record
HMO Technical Contact #3 Email	HMO Third Technical Contact Email	917	Header Record
HMO Technical Contact #3 First Name	HMO Third Technical Contact First Name	916	Header Record
HMO Technical Contact #3 Last Name	HMO Third Technical Contact Last Name	915	Header Record
ICD Procedure Code #1	Principle ICD Procedure Code	28	Detail Record
ICD Procedure Code #2	First Other ICD Procedure Code	29	Detail Record
ICD Procedure Code #3	Second Other ICD Procedure Code	30	Detail Record
ICD Procedure Code #4	Third Other ICD Procedure Code	31	Detail Record
ICD Procedure Code #5	Fourth Other ICD Procedure Code	32	Detail Record
ICD Procedure Code #6	Fifth Other ICD Procedure Code	33	Detail Record
Modifier Code #1	1st. Modifier Code	65	Detail Record
Modifier Code #2	2nd. Modifier Code	66	Detail Record
Modifier Code #3	3rd. Modifier Code	87	Detail Record
Modifier Code #4	4th. Modifier Code	88	Detail Record

Field Name to Number Cross-Reference

Field Name	*Old Name*	*Field#*	*Location*
National Place of Service		62	Detail Record
NDC Code		68	Detail Record
Number of Records Transmitted		905	Header Record
Other Provider		13	Detail Record
Patient Status Code		36	Detail Record
Performing Provider NPI		71	Detail Record
Performing Provider Name		72	Detail Record
Performing Provider Taxonomy		92	Detail Record
Performing Provider ZIP		93	Detail Record
Prescriber DEA		73	Detail Record
Prescription Date		60	Detail Record
Prescription Number		74	Detail Record
Procedure Code		64	Detail Record
Process Date		6	Detail Record
Quantity		69	Detail Record
Member First Name		11	Detail Record
Member ID		9	Detail Record
Member Last Name		10	Detail Record
Member Middle Initial		12	Detail Record
Record Identification Number		5	Detail Record
Record Type		4	Detail Record
Referring Provider NPI		15	Detail Record
Refill Indicator		75	Detail Record
Revenue Code		67	Detail Record
Submission Date		902	Header Record
To Date of Service		59	Detail Record
TPL Paid Amount		82	Detail Record
Unit Dose		76	Detail Record
Value Amount #1	Value Amount	39	Detail Record
Value Amount #2	Second Value Amount	41	Detail Record
Value Amount #3	Third Value Amount	43	Detail Record
Value Amount #4	Fourth Value Amount	45	Detail Record

Field Name to Number Cross-Reference

Field Name	*Old Name*	*Field#*	*Location*
Value Code #1	Value Code	38	Detail Record
Value Code #2	Second Value Code	40	Detail Record
Value Code #3	Third Value Code	42	Detail Record
Value Code #4	Fourth Value Code	44	Detail Record

Appendix B – Encounter Data Record Layout

Header Record Layout

Field #	*Field Name*	*Position*		*Format*	*Field Attributes*
		From	*Through*		
901	HMO ID	1	8	NUM (8)	Required
902	Submission Date	9	16	MMDDYYYY	Required
903	Beginning Process Date	17	24	MMDDYYYY	Required
904	Ending Process Date	25	32	MMDDYYYY	Required
905	Number Of Records Transmitted	33	40	NUM (8)	Required
906	HMO Contract Administrator Last Name	41	75	A/N (35)	Required
907	HMO Contract Administrator First Name	76	100	A/N (25)	Required
908	HMO Contract Administrator Email	101	150	A/N (50)	Required
909	HMO Technical Contact #1 Last Name	151	185	A/N (35)	Required
910	HMO Technical Contact #1 First Name	186	210	A/N (25)	Required
911	HMO Technical Contact #1 Email	211	260	A/N (50)	Required
912	Second Technical Contact Last Name	261	295	A/N (35)	Optional
913	Second Technical Contact First Name	296	320	A/N (25)	Optional
914	Second Technical Contact Email	321	370	A/N (50)	Optional
915	HMO Technical Contact #3 Last Name	371	405	A/N (35)	Optional
916	HMO Technical Contact #3 First Name	406	430	A/N (25)	Optional
917	HMO Technical Contact #3 Email	431	480	A/N (50)	Optional
918	Filler	481	722	A/N (242)	Optional

Format Definitions

NUM (numeric) the value is right justified and zero filled.

A/N (alpha-numeric) the value is left justified and space filled.

MMDDYYYY (date) the elements include any leading zero.

Field Attributes

Required (R)	The data element field must be provided on all encounter records.
Required, if applicable (RA)	The data element field is required based on encounter type and conditions present on the record. For example, Procedure Code is "required if applicable". If the encounter type is inpatient, outpatient, or medical and the revenue code is blank, then a procedure code is required.
Optional (O)	The data element may be provided by the HMO if there is a business decision to do so.
Never Required (N)	The data element field is not edited and is not loaded.

Detail Record Layout

Fld	*Field Name*	*Position*		*Size*	*Format, Justify, Fill*	*Encounter Types (Field Attributes)*					*Acceptable values*
		Start	*End*			*Dental*	*Inpatient*	*Outpatient*	*Medical*	*Pharmacy*	
1	Encounter Type	1	1	1	A/N	R	R	R	R	R	D, I, O, M, P
2	HMO ID	2	9	8	NUM	R	R	R	R	R	6900XXXX
3	Data Source	10	10	1	NUM	R	R	R	R	R	1, 2, 3
4	Record Type	11	11	1	A/N	R	R	R	R	R	R, O
5	Record Identification Number	12	41	30	A/N LJ BF	R	R	R	R	R	Any unique internal control number
6	Process Date	42	49	8	MMDDYYYY	R	R	R	R	R	
7	Billing Provider NPI	50	59	**10**	NUM	RA	R	RA	RA	RA	ForwardHealth Provider number or NPI for group/clinic/hospital
8	Billing Provider Name	60	94	35	A/N LJ BF	RA	R	RA	RA	RA	Name of group/clinic
90	**Billing Provider Taxonomy**	**95**	**104**	**10**	**A/N**	RA	R	RA	RA	RA	Valid Provider Taxonomy
91	**Billing Provider ZIP+4**	**105**	**113**	**9**	**NUM**	RA	R	RA	RA	RA	Provider ZIP Code
9	Member ID	114	**123**	**10**	NUM	R	R	R	R	R	Member ID

Fld	Field Name	Position		Size	Format, Justify, Fill	Encounter Types (Field Attributes)					Acceptable values
		Start	End			Dental	Inpatient	Outpatient	Medical	Pharmacy	
10	Member Last Name	124	158	35	A/N LJ BF	R	R	R	R	R	See Enrollment Report
11	Member First Name	159	183	25	A/N LJ BF	R	R	R	R	R	See Enrollment Report
12	Member Middle Initial	184	184	1	A/N LJ BF	O	O	O	O	O	See Enrollment Report
13	Other Provider (Surgical Provider)	185	219	35	A/N LJ BF	N	O	N	N	N	Name or number of physician who performed a procedure listed on the encounter
14	Attending Physician	220	254	35	A/N LJ BF	N	O	O	N	N	Name or number of physician who maintains primary responsibility for determining the patient's continued need for acute care and readiness for discharge, even when this physician has referred the patient to one or more consulting physicians
15	Referring Provider NPI	255	264	10	NUM	N	N	N	O	N	Referring Provider NPI or ForwardHealth ID
16	Facility Name/Number	265	299	35	A/N LJ BF	N	N	N	RA	O	Facility where service was performed
17	Principle Diagnosis Code	**300**	**307**	**8**	A/N LJ BF	N	R	R	R	N	ICD-9 Diagnosis Code (Note: most specific code required on all diagnoses Principle through #18)
18	Diagnosis Code #2	**308**	**315**	**8**	A/N LJ BF	N	RA	RA	RA	N	ICD-9 Diagnosis Code

Fld	Field Name	Position		Size	Format, Justify, Fill	Encounter Types (Field Attributes)					Acceptable values
		Start	End			Dental	Inpatient	Outpatient	Medical	Pharmacy	
19	Diagnosis Code #3	**316**	**323**	**8**	A/N LJ BF	N	RA	RA	RA	N	ICD-9 Diagnosis Code
20	Diagnosis Code #4	**324**	**331**	**8**	A/N LJ BF	N	RA	RA	RA	N	ICD-9 Diagnosis Code
21	Diagnosis Code #5	**332**	**339**	**8**	A/N LJ BF	N	RA	RA	RA	N	ICD-9 Diagnosis Code
22	Diagnosis Code #6	**340**	**347**	**8**	A/N LJ BF	N	RA	RA	RA	N	ICD-9 Diagnosis Code
23	Diagnosis Code #7	**348**	**355**	**8**	A/N LJ BF	N	RA	RA	RA	N	ICD-9 Diagnosis Code
24	Diagnosis Code #8	**356**	**363**	**8**	A/N LJ BF	N	RA	RA	RA	N	ICD-9 Diagnosis Code
25	Diagnosis Code #9	**364**	**371**	**8**	A/N LJ BF	N	RA	RA	RA	N	ICD-9 Diagnosis Code
94	**Diagnosis Code #10**	**372**	**379**	**8**	**A/N LJ BF**	N	RA	RA	RA	N	ICD-9 Diagnosis Code
95	**Diagnosis Code #11**	**380**	**387**	**8**	**A/N LJ BF**	N	RA	RA	RA	N	ICD-9 Diagnosis Code
96	**Diagnosis Code #12**	**388**	**395**	**8**	**A/N LJ BF**	N	RA	RA	RA	N	ICD-9 Diagnosis Code
97	**Diagnosis Code #13**	**396**	**403**	**8**	**A/N LJ BF**	N	RA	RA	RA	N	ICD-9 Diagnosis Code
98	**Diagnosis Code #14**	**404**	**411**	**8**	**A/N LJ BF**	N	RA	RA	RA	N	ICD-9 Diagnosis Code
99	**Diagnosis Code #15**	**412**	**419**	**8**	**A/N LJ BF**	N	RA	RA	RA	N	ICD-9 Diagnosis Code
100	**Diagnosis Code #16**	**420**	**427**	**8**	**A/N LJ BF**	N	RA	RA	RA	N	ICD-9 Diagnosis Code
101	**Diagnosis Code #17**	**428**	**435**	**8**	**A/N LJ BF**	N	RA	RA	RA	N	ICD-9 Diagnosis Code
102	**Diagnosis Code #18**	**436**	**443**	**8**	**A/N LJ BF**	N	RA	RA	RA	N	ICD-9 Diagnosis Code
103	**DX Version Indicator**	**444**	**444**	**1**	**A/N LJ BF**						9 - Ninth Revision 0 - Tenth Revision
26	Admission Diagnosis Code	**445**	**452**	**8**	**A/N LJ BF**	N	R	N	N	N	ICD-9 Diagnosis Code
28	ICD Procedure Code #1	453	457	5	A/N LJ BF	N	RA	N	N	N	Surgical Procedure Code
29	ICD Procedure Code #2	458	462	5	A/N LJ BF	N	RA	N	N	N	Surgical Procedure Code
30	ICD Procedure Code #3	463	467	5	A/N LJ BF	N	RA	N	N	N	Surgical Procedure Code

Fld	Field Name	Position		Size	Format, Justify, Fill	Encounter Types (Field Attributes)					Acceptable values
		Start	End			Dental	Inpatient	Outpatient	Medical	Pharmacy	
31	ICD Procedure Code #4	468	472	5	A/N LJ BF	N	RA	N	N	N	Surgical Procedure Code
32	ICD Procedure Code #5	473	477	5	A/N LJ BF	N	RA	N	N	N	Surgical Procedure Code
33	ICD Procedure Code #6	478	482	5	A/N LJ BF	N	RA	N	N	N	Surgical Procedure Code
34	Admission Type	483	483	1	NUM	N	R	N	N	N	1, 2, 3, 4
35	Admission Source	484	484	1	A/N	N	O	N	N	N	See UB-04 Manual for proper values
36	Patient Status Code	485	486	2	NUM RJ ZF	N	R	N	N	N	See UB-04 Manual for proper values
37	Admission Date	487	494	8	MMDDYYYY	N	R	N	N	N	MMDDYYYY
38	Value Code #1	495	496	2	A/N RJ ZF	N	O	O	N	N	See UB-04 Manual for proper values
39	Value Amount #1	497	503	7.2	NUM RJ BF	N	O	O	N	N	Implied decimal, 2 places
40	Value Code #2	504	505	2	A/N RJ ZF	N	O	O	N	N	See UB-04 Manual for proper values
41	Value Amount #2	506	512	7.2	NUM RJ BF	N	O	O	N	N	Implied decimal, 2 places
42	Value Code #3	513	514	2	A/N RJ ZF	N	O	O	N	N	See UB-04 Manual for proper values
43	Value Amount #3	515	521	7.2	NUM RJ BF	N	O	O	N	N	Implied decimal, 2 places
44	Value Code #4	522	523	2	A/N RJ ZF	N	O	O	N	N	See UB-04 Manual for proper values
45	Value Amount #4	524	530	7.2	NUM RJ BF	N	O	O	N	N	Implied decimal, 2 places

Fld	Field Name	Position		Size	Format, Justify, Fill	Encounter Types (Field Attributes)					Acceptable values
		Start	End			Dental	Inpatient	Outpatient	Medical	Pharmacy	
58	From Date of Service	531	538	8	MMDDYYYY	R	R	R	R	N	
59	To Date of Service	539	546	8	MMDDYYYY	N	R	RA	RA	N	
60	Prescription Date	547	554	8	MMDDYYYY	N	N	N	N	R	
61	Fill Date	555	562	8	MMDDYYYY	N	N	N	N	R	
62	National Place of Service (POS)	563	564	2	NUM RJ	R	N	N	R	O	See HCFA web site (www.hcfa.gov/medicare/edi/h1500.txt)
64	Procedure Code	565	569	5	A/N LJ BF	R	RA	RA	RA	N	CPT, HCPCS codes
65	Modifier 1	570	571	2	A/N	RA	N	RA	RA	N	CPT, HCPCS Modifier
66	Modifier 2	572	573	2	A/N	RA	N	RA	RA	N	CPT, HCPCS Modifier
87	Modifier 3	574	575	2	A/N	RA	N	RA	RA	N	CPT, HCPCS Modifier
88	Modifier 4	576	577	2	A/N	RA	N	RA	RA	N	CPT, HCPCS Modifier
67	Revenue Code	578	581	4	NUM RJ ZF	N	RA	RA	RA	N	See UB-04 Manual for proper values
68	NDC Code	582	592	11	A/N	N	N	N	N	R	National Drug Code
69	Quantity	593	601	9.3	NUM RJ ZF	R	R	R	R	R	Implied decimal, 3 places
70	Days Supply	602	604	3	NUM RJ ZF	N	N	N	N	R	
71	Performing Provider NPI	605	614	10	NUM LJ BF	RA	RA	RA	RA	RA	ForwardHealth provider number or NPI for performer.
72	Performing Provider name	615	649	35	A/N LF BF	RA	RA	RA	RA	RA	Name of performing provider
92	**Performing Provider Taxonomy**	**650**	**659**	**10**	**A/N**	RA	RA	RA	RA	RA	Taxonomy of the Performing Provider
93	**Performing Provider ZIP+4**	**660**	**668**	**9**	**NUM**	RA	RA	RA	RA	RA	Zip+4 of the Performing Provider

Fld	*Field Name*	*Position*		*Size*	*Format, Justify, Fill*	*Encounter Types (Field Attributes)*					*Acceptable values*
		Start	*End*			*Dental*	*Inpatient*	*Outpatient*	*Medical*	*Pharmacy*	
73	Prescriber DEA Number	669	678	**10**	A/N LJ BF	N	N	N	N	R	See monthly electronic provider file
74	Prescription Number	679	686	8	A/N LF BF	N	N	N	N	R	
75	Refill Indicator	687	688	2	NUM RJ ZF	N	N	N	N	R	0-99
76	Unit Dose	689	689	1	NUM	N	N	N	N	R	0,1,2,3
77	DAW	690	690	1	NUM	N	N	N	N	R	Dispense as written 0-8
78	Emergency Service Indicator	691	691	1	A/N	N	N	N	R	N	Y=yes, N=no, U=unknown
79	HealthCheck Indicator	692	692	1	A/N	R	N	N	R	N	Y=yes, N=no, U=unknown
80	Family Planning Indicator	693	693	1	A/N	N	N	N	R	N	Y=yes, N=no, U=unknown
89	**Financial Indicator**	**694**	**694**	**1**	**A/N**						Y = HMO paid or would have paid for the service. Setting this indicator to "Y" will result in the encounter record being processed by the costing system. The costing process will not look at the ANSI code financial user indicators to determine if the encounter should be priced. N = HMO did not pay and would not have paid for the service. Setting this indicator to "N" will result in the encounter record being

Fld	Field Name	Position		Size	Format, Justify, Fill	Encounter Types (Field Attributes)					Acceptable values
		Start	End			Dental	Inpatient	Outpatient	Medical	Pharmacy	
											excluded from the costing process. The encounter will NOT be priced. The costing process will not look at the ANSI code financial user indicators to determine if the encounter should be priced. Blank - HMO has not indicated if the encounter whether or not the encounter was paid. A blank value will result in the encounter being included or excluded from the costing process based on the setting of the financial user indicator associated with all ANSI codes associated with the encounter. To be include in the costing process all ANSI codes associated with the encounter must have financial use indicators of "Y".
81	Charge	695	703	9.2	NUM RJ ZF	R	R	R	R	R	Implied decimal, 2 places
82	TPL Paid Amount	704	710	7.2	NUM RJ ZF	RA	RA	RA	RA	RA	Implied decimal, 2 places

Fld	*Field Name*	*Position*		*Size*	*Format, Justify, Fill*	*Encounter Types (Field Attributes)*					*Acceptable values*
		Start	*End*			*Dental*	*Inpatient*	*Outpatient*	*Medical*	*Pharmacy*	
83	ANSI/NCPDP Code #1	711	713	3	A/N LJ BF	RA	RA	RA	RA	RA	See Appendix G, H
84	ANSI/NCPDP Code #2	714	716	3	A/N LF BF	RA	RA	RA	RA	RA	See Appendix G, H
85	ANSI/NCPDP Code #3	717	719	3	A/N LJ BF	RA	RA	RA	RA	RA	See Appendix G, H
86	ANSI/NCPDP Code #4	720	722	3	A/N LJ BF	RA	RA	RA	RA	RA	See Appendix G, H

Format Definitions
A/N = alphanumeric (uppercase A – Z, 0 – 9)
NUM = numeric (0 – 9)
LJ = the value is left justified
RJ = the value is right justified
BF = the value is blank filled
ZF = the value is zero filled. Note that if a value is not available for a field and is not required, the entire field should be left blank, not filled with all zeros.
MMDDYYYY (date) the elements include any leading zero

**** If BF or ZF is not specified, then the value must be the exact number of characters.**

Appendix C – File Naming Conventions

Zip File			
Order	**Contents**	**Description**	
1	**HMO**	HMO Base Payer Identification Number	
2	**Submission type**	• E" for normal submission; "R" for reconciliation submission	
3	Submission	• date Submission date (YYYYMMDD)	
4	**Sequence**	(S) 1 for first submission of month, 2 for second, etc.	
5		Numeric sequence (1-999)	
6	"TEST	(required for test submissions, omit for production submissions)	
7	**File extension**	.zip	
Examples	The August 2008 submission of encounter data		6900xxxxE20080801mmddSn.zip
	The April 2008 submission of encounter **test** data		6900xxxxE20081101SnTEST.zip

Text file
anything_within_reason.txt

Appendix D – SFTP

092308

I. SFTP SERVER SET UP

1. EDS will send a email to the HMO requesting the name, address, email address and phone number for each user account requested.
2. If this is a new HMO inform the contact(s) that SFTP is required.
3. Send the user account information to VEDSHMOSupport@wisconsin.gov
4. Upon receipt of the user account information HMO Support will send an email with a Contract Notice to each individual staff member for whom an account was requested.
5. Once the accounts are set up and the completed Contract notice is received the HMO Support team will send an email notification providing the folder name(s), the user id and password for the new user account. The password will be sent in a separate email.
6. The first log in requires the use of WINSCP, putty or other third party software that will allow a user to sign on for the first time and immediately change their password. HMO Support will work with the HMO to resolve any connection problems however due to the plethora of SFTP software packages available the HMO support team may not be familiar with the HMOs particular SFTP software. In those situations the support team may request that you install either WINSCP or Putty in order to verify that the HMO can log in using a software application that has been proven to work for the HMO SFTP server configuration.

   NOTE: WinSCP is an open source SFTP client and FTP client for Windows. Its main function is the secure file transfer between a local and a remote computer. Beyond this, WinSCP offers basic file manager functionality. It uses Secure Shell (SSH). WinSCP can be downloaded at http://winscp.net/

7. Create a new session by highlighting the session in the box on the right. This will open the session window.
8. Enter the IP address (63.240.249.236), User ID and Password.
9. Select SFTP from the drop down box.
10. Check the box labeled Allow SCP fallback.
11. Select the Save button to save the session.
12. Once the session is successfully saved select the stored sessions options.
13. Highlight the session that was just created.
14. Select the Login button.
15. When the Authentication banner is shown select continue.
16. When the login display is shown, add the password provided by EDS.
17. Upon successful login change the password.
18. Each HMO has two main folders available the User acceptance testing folder and the production folder.

19. The HMO login will determine which folder is accessed. Each user is given one user id and password for the production environment and one user id and password for the user acceptance testing environment.

20. Once the user logs in to the correct environment the following folders will be visible.

    etc
    incoming
    lib
    outgoing
    platform
    usr

21. To Upload files to be processed by the encounter application. The HMO will place the submission folder in the incoming folder.

22. Upon email notification of completion of the submission. The HMO will access the outgoing folder to download the SSR.

Common Problems

1. Software doesn't allow the user to get a prompt for the first time. Download putty or WINSCP for use with the first login.

   Note: WINSCP provides a GUI. Putty is a command line product.

2. Not utilizing the Password Rules

3. Not utilizing SFTP software. Ask the user what software they are using and assure that it is SFTP.

SFTP server password rules are as follows:

1. Can not use previous passwords.
2. The first 8 characters of the old and new passwords must differ by at least 7 positions.
3. The password must have at least 1 number.
4. The password must contain at least 1 special character which can not be the last character of the password.
5. The first 8 characters of the password must contain at least 2 uppercase and 2 lowercase alpha characters.
6. The password can NOT have any white spaces.
7. The password must have at least 4 alpha characters.
8. The password must be at least 8 characters long.

Appendix G – ANSI Codes (Claim Adjustment Reason Codes)

Understanding *This refers to a record that contains critical error(s) and includes this ANSI code in any of the four ANSI fields.*

Correction Required

"Y" - the HMO should submit a corrected record. The record is placed in the Error table.
"N" - the HMO has the option of submitting a corrected record. The record is placed in the Accepted table.

ANSI Code	*ANSI Code Description*	*Correction Required*	*DHCAA Fin Use*	*DHCAA Util*
193	Original payment decision is being maintained. This claim was processed properly the first time.	N	N	N
194	Payment adjusted when anesthesia is performed by the operating physician, the assistant surgeon or the attending physician	Y	Y	Y
195	Payment denied/reduced due to a refund issued to an erroneous priority payer for this claim/service	Y	N	Y
196	Claim/service denied based on prior payer's coverage determination.	Y	N	Y
167	This (these) diagnosis(es) is (are) not covered	Y	N	N
168	Payment denied as Service(s) have been considered under the patients medical plan. Benefits are not available under this dental plan	Y	Y	N
169	Payment adjusted because an alternate benefit has been provided	Y	Y	Y
170	Payment is denied when performed/billed by this type of provider	Y	N	Y
171	Payment is denied when performed/billed by this type of provider in this type of facility	Y	Y	N
172	Payment is adjusted when performed/billed by a provider of this specialty	Y	Y	Y
173	Payment adjusted because this service was not prescribed by a physician	Y	Y	Y
174	Payment denied because this service was not prescribed prior to delivery	N	Y	N
175	Payment denied because the prescription is incomplete	N	N	N
176	Payment denied because the prescription is not current	N	Y	N
177	Payment denied because the patient has not met the required eligibility requirements	N	N	N
178	Payment adjusted because the patient has not met the required spend down requirements	Y	Y	Y
179	Payment adjusted because the patient has not met the required waiting requirements	Y	Y	Y
180	Payment adjusted because the patient has not met the required residency requirements	N	N	N
181	Payment adjusted because this procedure code was invalid on the date of service	N	N	N
182	Payment adjusted because the procedure modifier was invalid on the date of service	Y	N	Y
183	The referring provider is not eligible to refer the service billed.	Y	Y	N
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed	Y	N	Y
185	The rendering provider is not eligible to perform the service billed	Y	N	Y

ANSI Code	ANSI Code Description	Correction Required	DHCAA Fin Use	DHCAA Util
186	Payment adjusted since the level of care changed	Y	Y	Y
187	Health Savings account payments	Y	Y	Y
188	This product/procedure is only covered when used according to FDA recommendation	Y	Y	N
189	"Not otherwise classified" or "unlisted" procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service	N	N	N
D21	This (these) diagnosis(es) is (are) missing or are invalid	N	N	N
190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay	Y	Y	Y
191	Claim denied because this is not a work related injury/illness and thus not the liability of the workers' compensation carrier.	N	N	N
192	Non standard adjustment code from paper remittance advice	N	N	N
197	Payment adjusted for absence of precertification/authorization. This change effective 1/1/2008: Payment adjusted for absence of precertification/authorization/notification.	Y	Y	Y
198	Payment Adjusted for exceeding precertification/ authorization.	Y	Y	Y
199	Revenue code and Procedure code do not match.	N	N	N
200	Expenses incurred during lapse in coverage	Y	N	Y
201	Workers Compensation case settled. Patient is responsible for amount of this claim/service through WC "Medicare set aside arrangement" or other agreement. (Use group code PR).	Y	N	Y
202	Payment adjusted due to non-covered personal comfort or convenience services.	Y	Y	Y
203	Payment adjusted for discontinued or reduced service.	Y	Y	Y
204	This service/equipment/drug is not covered under the patient's current benefit plan	Y	N	Y
205	Pharmacy discount card processing fee	N	N	N
207	NPI denial - Invalid format	N	N	N
208	NPI denial - not matched	N	N	N
209	Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use Group code OA)	Y	N	Y
210	Payment adjusted because pre-certification/authorization not received in a timely fashion	Y	Y	Y
211	National Drug Codes (NDC) not eligible for rebate, are not covered.	Y	N	Y
206	NPI denial - missing	N	N	N
166	These services were submitted after this payer's responsibility for processing claims under this plan ended.	N	N	Y
212	Administrative surcharges are not covered	Y	Y	Y

ANSI Code	*ANSI Code Description*	*Correction Required*	*DHCAA Fin Use*	*DHCAA Util*
1	Deductible amount	Y	Y	Y
2	Coinsurance amount	Y	Y	Y
3	Co-payment amount	Y	Y	Y
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	N	N	N
5	The procedure code/bill type is inconsistent with the place of service	N	N	N
6	The procedure code is inconsistent with the patient's age	N	N	N
7	The procedure code is inconsistent with the patient's gender	N	N	N
8	The procedure code is inconsistent with the provider type	N	N	N
9	The diagnosis is inconsistent with the patient's age	N	N	N
10	The diagnosis is inconsistent with the patient's gender	N	N	N
11	The diagnosis is inconsistent with the procedure	N	N	N
12	The diagnosis is inconsistent with the provider type	N	N	N
13	The date of death precedes the date of service	N	N	N
14	The date of birth follows the date of service	N	N	N
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services	Y	Y	Y
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).	N	N	N
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).	N	Y	Y
18	Duplicate claim/service	N	N	N
19	Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier	Y	N	Y
20	Claim denied because this injury/illness is covered by the liability carrier	Y	N	Y
21	Claim denied because this injury/illness is the liability of the no-fault carrier	Y	N	Y
22	Payment adjusted because this care may be covered by another payer per coordination of benefits	Y	Y	Y
23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	Y	Y	Y
24	Payment for charges adjusted. Charges are covered under a capitation agreement	Y	Y	Y
25	Payment denied Your stop loss deductible has not been met	Y	Y	Y
26	Expenses incurred prior to coverage	N	N	N
27	Expenses incurred after coverage terminated	N	N	N
28	Coverage not in effect at the time the service was provided	N	N	N
29	The time limit for filing has expired	Y	N	Y

ANSI Code	ANSI Code Description	Correction Required	DHCAA Fin Use	DHCAA Util
30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.	N	N	N
31	Claim denied as patient cannot be identified as our insured	N	N	N
32	Our records indicate that this dependent is not an eligible dependent as defined	Y	N	Y
33	Claim denied Insured has no dependent coverage	Y	N	Y
34	Claim denied Insured has no coverage for newborns	Y	N	Y
35	Benefit maximum has been reached	Y	N	Y
36	Balance does not exceed co-payment amount	Y	Y	Y
37	Balance does not exceed deductible	Y	Y	Y
38	Services not provided or authorized by designated (network) providers	Y	N	Y
39	Services denied at the time authorization/pre-certification was requested	Y	N	Y
40	Charges do not meet qualifications for emergent/urgent care	Y	Y	Y
41	Discount agreed to in Preferred Provider contract	Y	Y	Y
42	Charges exceed our fee schedule or maximum allowable amount	Y	Y	Y
43	Gramm-Rudman reduction	Y	Y	Y
44	Prompt-pay discount	Y	Y	Y
45	Charges exceed your contracted/ legislated fee arrangement	Y	Y	Y
46	This (these) service(s) is (are) not covered	Y	N	Y
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	N	N	N
48	This (these) procedure(s) is (are) not covered	Y	N	Y
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam	N	N	N
50	These are non-covered services because this is not deemed a `medical necessity' by the payer	Y	N	Y
51	These are non-covered services because this is a pre-existing condition	Y	N	Y
52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed	Y	N	Y
53	Services by an immediate relative or a member of the same household are not covered	Y	N	Y
54	Multiple physicians/assistants are not covered in this case	Y	N	Y
55	Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer	Y	N	Y
56	Claim/service denied because procedure/treatment has not been deemed `proven to be effective' by the payer	Y	N	Y
57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage	Y	Y	Y
58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.	N	Y	Y
59	Charges are adjusted based on multiple surgery rules, assistant surgery rules, or concurrent anesthesia rules	Y	Y	Y

ANSI Code	ANSI Code Description	Correction Required	DHCAA Fin Use	DHCAA Util
60	Charges for outpatient services with this proximity to inpatient services are not covered	N	N	N
61	Charges adjusted as penalty for failure to obtain second surgical opinion	Y	Y	Y
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization	Y	Y	Y
63	Correction to a prior claim	Y	Y	Y
64	Denial reversed per Medical Review	Y	Y	Y
65	Procedure code was incorrect This payment reflects the correct code	Y	Y	Y
66	Blood Deductible	Y	N	Y
67	Lifetime reserve days	Y	Y	Y
68	DRG weight	Y	Y	Y
69	Day outlier amount	Y	Y	Y
70	Cost outlier - Adjustment to compensate for additional costs.	Y	Y	Y
71	Primary payer amount	Y	Y	Y
72	Coinsurance day	Y	Y	Y
73	Administrative days	Y	Y	Y
74	Indirect medical education adjustment	Y	Y	Y
75	Direct medical education adjustment	Y	Y	Y
76	Disproportionate share adjustment	Y	Y	Y
77	Covered days	Y	Y	Y
78	Non-covered days/room charge adjustment	Y	Y	Y
79	Cost report days	Y	Y	Y
80	Outlier days	Y	Y	Y
81	Discharges	Y	Y	Y
82	PIP days	Y	Y	Y
83	Total visits	Y	Y	Y
84	Capital adjustment	Y	Y	Y
85	Interest amount	Y	Y	Y
86	Statutory adjustment	Y	Y	Y
87	Transfer amount	Y	Y	Y
88	Adjustment amount represents collection against receivable created in prior overpayment	Y	Y	Y
89	Professional fees removed from charges	Y	Y	Y
90	Ingredient cost adjustment	Y	Y	Y
91	Dispensing fee adjustment	Y	Y	Y
92	Claim paid in full	Y	Y	Y
93	No Claim level adjustments	Y	Y	Y
94	Processed in excess of charges	Y	Y	Y
95	Benefits adjusted. Plan procedures not followed.	Y	Y	Y

ANSI Code	ANSI Code Description	Correction Required	DHCAA Fin Use	DHCAA Util
96	Non-covered change(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).	Y	N	Y
97	Payment is included in the allowance for another service/procedure.	N	N	N
98	The hospital must file the Medicare claim for this inpatient non-physician service	N	N	N
99	Medicare secondary payer adjustment amount	Y	Y	Y
100	Payment made to patient/insured/responsible party	Y	Y	Y
101	Predetermination, anticipated payment upon completion of services or claim adjudication.	Y	Y	Y
102	Major Medical adjustment	Y	Y	Y
103	Provider promotional discount (ie senior citizen discount)	Y	Y	Y
104	Managed care withholding	Y	Y	Y
105	Tax withholding	Y	Y	Y
106	Patient payment option/election not in effect	Y	Y	Y
107	Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim	N	N	N
108	Payment reduced because rent/purchase guidelines were not met	Y	Y	Y
109	Claim not covered by this payer/contractor You must send the claim to the correct payer/contractor	N	N	N
110	Billing date predates service date	N	N	N
111	Not covered unless the provider accepts assignment	Y	Y	Y
112	Payment adjusted as not furnished directly to the patient and/or not documented	N	N	N
113	Payment denied because service/procedure was provided outside the United States or as a result of war	Y	N	Y
114	Procedure/product not approved by the Food and Drug Administration	Y	N	Y
115	Payment adjusted as procedure postponed or canceled	N	N	N
116	Payment denied The advance indemnification notice signed by the patient did not comply with requirements	Y	N	Y
117	Payment adjusted because transportation is only covered to the closest facility that can provide the necessary care	Y	Y	Y
118	Charges reduced for ESRD network support	Y	Y	Y
119	Benefit maximum for this time period has been reached	Y	N	Y
120	Patient is covered by a managed care plan	Y	Y	Y
121	Indemnification adjustment	Y	Y	Y
122	Psychiatric reduction	Y	N	Y
123	Payer refund due to overpayment	Y	Y	Y
124	Payer refund amount - not our patient	N	N	N
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).	Y	Y	Y

ANSI Code	ANSI Code Description	Correction Required	DHCAA Fin Use	DHCAA Util
126	Deductible - Major Medical	Y	Y	Y
127	Coinsurance - Major Medical	Y	Y	Y
128	Newborn's services are covered in the mother's allowance	Y	Y	Y
129	Claim denied - prior processing information appears incorrect	N	N	N
130	Claim submission fee	Y	Y	Y
131	Claim specific negotiated discount	Y	Y	Y
132	Prearranged demonstration project adjustment	Y	Y	Y
133	The disposition of this claim/service is suspended pending further review	Y	Y	Y
134	Technical fees removed from charges	Y	Y	Y
135	Claim denied. Interim bills cannot be processed	N	N	N
136	Claim denied/reduced Plan procedures of a prior payer were not followed	Y	N	Y
137	Payment/Reduction for regulatory surcharges, Assessments, Allowances or Health Related Taxes	Y	Y	Y
138	Claim/service denied. Appeal procedures not followed or time limits not met	Y	N	Y
139	Contracted funding agreement - Subscriber is employed by the provider of services.	Y	Y	Y
140	Patient/Insured health identification number and name do not match	N	N	N
141	Claim adjustment because the claim spans eligible and ineligible periods of coverage	Y	Y	Y
142	Claim adjusted by the monthly ForwardHealth patient liability amount.	Y	Y	Y
143	Portion of payment deferred.	Y	Y	Y
144	Incentive adjustment, e.g. preferred product/service.	Y	Y	Y
145	Premium payment withholding	Y	Y	Y
146	Payment denied because the diagnosis was invalid for the date(s) of service reported.	N	N	N
147	Provider contracted/negotiated rate expired or not on file.	Y	N	Y
148	Claim/service rejected at this time because information from another provider was not provided or was insufficient/incomplete.	Y	N	N
149	Lifetime benefit maximum has been reached for this service/benefit category	Y	N	Y
150	Payment adjusted because the payer deems the information submitted does not support this level of service	Y	Y	Y
151	Payment adjusted because the payer deems the information submitted does not support this many services	Y	Y	Y
152	Payment adjusted because the payer deems the information submitted does not support this length of service	Y	Y	Y
153	Payment adjusted because the payer deems the information submitted does not support this dosage	Y	Y	Y
154	Payment adjusted because the payer deems the information submitted does not support this day's supply	Y	Y	Y
155	This claim is denied because the patient refused the service/procedure.	N	N	N
156	Flexible spending accounts payments	Y	Y	Y

ANSI Code	*ANSI Code Description*	*Correction Required*	*DHCAA Fin Use*	*DHCAA Util*
157	Payment denied/reduced because service/procedure was provided as a result of an act of war	Y	Y	Y
158	Payment denied/reduced because the service/procedure was provided outside of the United States	Y	Y	Y
159	Payment denied/reduced because the service/procedure was provided as a result of terrorism.	Y	Y	Y
160	Payment denied/reduced because injury/illness was the result of an activity that is a benefit exclusion	Y	Y	Y
161	Provider performance bonus	Y	Y	Y
162	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation.	Y	Y	Y
163	Claim/Service adjusted because the attachment referenced on the claim was not received	Y	Y	Y
164	Claim Service adjusted because the attachment referenced on the claim was not received in a timely fashion	Y	Y	Y
165	Payment denied /reduced for absence of, or exceeded referral	Y	N	Y

ANSI Code	ANSI Code Description	Correction Required	DHCAA Fin Use	DHCAA Util
A0	Patient refund amount	Y	Y	Y
A1	Claim denied charges	N	N	N
A2	Contractual adjustment	Y	Y	Y
A3	Medicare secondary payer liability met	Y	Y	Y
A4	Medicare claim PPS capital day outlier amount	Y	Y	Y
A5	Medicare claim PPS capital cost outlier amount	Y	Y	Y
A6	Prior hospitalization or 30 day transfer requirement not met	Y	Y	Y
A7	Presumptive Payment Adjustment	Y	Y	Y
A8	Claim denied; ungroupable DRG	N	N	N
B1	Non-covered visits	Y	N	Y
B2	Covered visits	Y	Y	Y
B3	Covered charges	Y	Y	Y
B4	Late filing penalty	Y	Y	Y
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded	Y	Y	Y
B6	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.	Y	Y	Y
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service	Y	N	Y
B8	Claim/service not covered/reduced because alternative services were available, and should have been utilized	Y	N	Y
B9	Services not covered because the patient is enrolled in a hospice	N	N	N
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid The beneficiary is not liable for more than the charge limit for the basic procedure/test	Y	Y	Y
B11	The claim/service has been transferred to the proper payer/processor for processing Claim/service not covered by this payer/processor	N	N	N
B12	Services not documented in patients' medical records	N	N	N
B13	Previously paid Payment for this claim/service may have been provided in a previous payment	N	N	N
B14	Payment denied because only one visit or consultation per physician per day is covered	Y	N	Y
B15	Payment adjusted because this procedure/service is not paid separately	N	N	N
B16	Payment adjusted because `New Patient' qualifications were not met	Y	Y	Y
B17	Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.	N	N	N

ANSI Code	*ANSI Code Description*	*Correction Required*	*DHCAA Fin Use*	*DHCAA Util*
B18	Payment adjusted because this procedure code and modifier were invalid on the date of service	N	Y	Y
B19	Claim/service denied/reduced because of the finding of a review organization	Y	Y	Y
B20	Payment adjusted because procedure/service was partially or fully furnished by another provider	N	Y	Y
B21	The charges were reduced because the service/care was partially furnished by another physician	Y	N	Y
B22	This payment is adjusted based on the diagnosis.	Y	Y	Y
B23	Claim/ service denied because this provider has failed an aspect of a proficiency testing program	N	N	N
D1	Claim/service denied Level of subluxation is missing or inadequate	N	N	N
D2	Claim lacks the name, strength, or dosage of the drug furnished	N	N	N
D3	Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing	N	N	N
D4	Claim/service does not indicate the period of time for which this will be needed	N	N	N
D5	Claim/service denied Claim lacks individual lab codes included in the test	N	N	N
D6	Claim/service denied Claim did not include patient's medical record for the service	N	N	N
D7	Claim/service denied Claim lacks date of patient's most recent physician visit	N	N	N
D8	Claim/service denied Claim lacks indicator that `x-ray is available for review'	N	N	N
D9	Claim/service denied Claim lacks invoice or statement certifying the actual cost of the lens, less discounts or the type of intraocular lens used	N	N	N
D10	Claim/service denied Completed physician financial relationship form not on file	N	N	N
D11	Claim lacks completed pacemaker registration form	N	N	N
D12	Claim/service denied Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test	N	N	N
D13	Claim/service denied Performed by a facility/supplier in which the ordering/referring physician has a financial interest	Y	N	Y
D14	Claim lacks indication that plan of treatment is on file	N	N	N
D15	Claim lacks indication that service was supervised or evaluated by a physician	N	N	N
D16	Claim lacks prior payer payment information.	N	N	N
D17	Claim/Service has invalid non-covered days.	N	N	N
D18	Claim/Service has missing diagnosis information.	N	N	N
D19	Claim/Service lacks Physician/Operative or other supporting documentation	N	N	N
D20	Claim/Service missing service/product information.	N	N	N
W1	Workers Compensation State Fee Schedule Adjustment	Y	N	Y

Appendix H - NCPDP Reject Codes

Note: all NCPDP Reject Codes are considered "Correction Required" No and "DHCAA Fin Use" No.

Reject Code	*Explanation*
01	MISSING/INVALID BIN
02	MISSING/INVALID VERSION NUMBER
03	MISSING/INVALID TRANSACTION CODE
04	MISSING/INVALID PROCESSOR CONTROL NUMBER
05	MISSING/INVALID PHARMACY NUMBER
06	MISSING/INVALID GROUP NUMBER
07	MISSING/INVALID CARDHOLDER ID NUMBER
08	MISSING/INVALID PERSON CODE
09	MISSING/INVALID BIRTHDATE
10	MISSING/INVALID SEX CODE
11	MISSING/INVALID RELATIONSHIP CODE
12	MISSING/INVALID CUSTOMER LOCATION CODE
13	MISSING/INVALID OTHER COVERAGE CODE
14	MISSING/INVALID ELIGIBILITY OVERRIDE CODE
15	MISSING/INVALID DATE FILLED/DATE OF SERVICE
16	MISSING/INVALID PRESCRIPTION NUMBER
17	MISSING/INVALID NEW-REFILL CODE
18	MISSING/INVALID METRIC QUANTITY
19	MISSING/INVALID DAYS SUPPLY
1C	MISSING/INVALID Smoker/Non-Smoker Code
1E	MISSING/INVALID Prescriber Location Code
20	MISSING/INVALID COMPOUND CODE
21	MISSING/INVALID NDC NUMBER
22	MISSING/INVALID DISPENSE AS WRITTEN CODE
23	MISSING/INVALID INGREDIENT COST
24	MISSING/INVALID SALES TAX
25	MISSING/INVALID PRESCRIBER DEA
26	MISSING/INVALID Unit Of Measure
28	MISSING/INVALID DATE PRESCRIPTION WRITTEN
29	MISSING/INVALID NUMBER REFILLS AUTHORIZED
2C	MISSING/INVALID Pregnancy Indicator
2E	MISSING/INVALID Primary Care Provider ID Qualifier
30	MISSING/INVALID P.A./M.C. CODE AND NUMBER
32	MISSING/INVALID LEVEL OF SERVICE

Reject Code	*Explanation*
33	MISSING/INVALID PRESCRIPTION ORIGIN CODE
34	MISSING/INVALID PRESCRIPTION DENIAL OVERRIDE
35	MISSING/INVALID PRIMARY PRESCRIBER
36	MISSING/INVALID CLINIC ID
38	MISSING/INVALID BASIS OF COST
39	MISSING/INVALID DIAGNOSIS CODE
3A	MISSING/INVALID REQUEST TYPE
3B	MISSING/INVALID REQUEST PERIOD DATE-BEGIN
3C	MISSING/INVALID REQUEST PERIOD DATE-END
3D	MISSING/INVALID BASIS OF REQUEST
3E	MISSING/INVALID AUTHORIZED REPRESENTATIVE FIRST NAME
3F	MISSING/INVALID AUTHORIZED REPRESENTATIVE LAST NAME
3G	MISSING/INVALID AUTHORIZED REPRESENTATIVE ADDRESS
3H	MISSING/INVALID AUTHORIZED REPRESENTATIVE CITY
3J	MISSING/INVALID AUTHORIZED REPRESENTATIVE STATE
3K	MISSING/INVALID AUTHORIZED REPRESENTATIVE ZIP
3M	MISSING/INVALID PRESCRIBER TELEPHONE NUMBER
3N	MISSING/INVALID PRIOR AUTHORIZED NUMBER ASSIGNED
3P	MISSING/INVALID AUTHORIZATION NUMBER
3R	PRIOR AUTHORIZATION NOT REQUIRED
3S	SUPPORTING DOCUMENTATION REQUIRED
3T	ACTIVE PRIOR AUTHORIZATION EXISTS RESUBMIT AT EXPIRATION OF PRIOR AUTHORIZATION
3W	PRIOR AUTHORIZATION IN PROCESS
3X	AUTHORIZATION NUMBER NOT FOUND
3Y	PRIOR AUTHORIZATION DENIED
40	PHARMACY NOT CONTRACTED WITH PLAN ON DATE OF SERVICE
41	SUBMIT BILL TO OTHER PROCESSOR OR PRIMARY PAYOR
4C	MISSING/INVALID Coordination Of Benefits/Other Payments C
4E	MISSING/INVALID Primary Care Provider Last Name
50	NON-MATCHED PHARMACY NUMBER
51	NON-MATCHED GROUP NUMBER
52	NON-MATCHED CARDHOLDER ID
53	NON-MATCHED PERSON CODE
54	NON-MATCHED NDC NUMBER
55	NON-MATCHED NDC PACKAGE SIZE
56	NON-MATCHED PRESCRIBER DEA

Reject Code	*Explanation*
57	NON-MATCHED P.A./M.C. NUMBER
58	NON-MATCHED PRIMARY PRESCRIBER
59	NON-MATCHED CLINIC ID
5C	MISSING/INVALID Other Payer Coverage Type
5E	MISSING/INVALID Other Payer Reject Count
60	DRUG NOT COVERED FOR PATIENT AGE
61	DRUG NOT COVERED FOR PATIENT GENDER
62	PATIENT/CARD HOLDER ID NAME MISMATCH
63	INSTITUTIONALIZED PATIENT. NDC NOT COVERED
64	CLAIM SUBMITTED DOES NOT MATCH PRIOR AUTHORIZATION
65	PATIENT IS NOT COVERED
66	PATIENT AGE EXCEEDS MAXIMUM AGE
67	FILLED BEFORE COVERAGE EFFECTIVE
68	FILLED AFTER COVERAGE EXPIRED
69	FILLED AFTER COVERAGE TERMINATED
6C	MISSING/INVALID Other Payer ID Qualifier
6E	MISSING/INVALID Other Payer Reject Code
70	NDC NOT COVERED
71	PRESCRIBER IS NOT COVERED
72	PRIMARY PRESCRIBER IS NOT COVERED
73	REFILLS ARE NOT COVERED
74	OTHER CARRIER PAYMENT MEETS OR EXCEEDS PAYABLE
75	PRIOR AUTHORIZATION REQUIRED
76	PLAN LIMITATIONS EXCEEDED
77	DISCONTINUED NDC NUMBER
78	COST EXCEEDS MAXIMUM
79	REFILL TOO SOON
80	DRUG-DIAGNOSIS MISMATCH
81	CLAIM TOO OLD
82	CLAIM IS POST-DATED
83	DUPLICATE PAID/CAPTURED CLAIM
84	CLAIM HAS NOT BEEN PAID/CAPTURED
85	CLAIM NOT PROCESSED
86	SUBMIT MANUAL REVERSAL
87	REVERSAL NOT PROCESSED
88	DUR REJECT ERROR

Reject Code	*Explanation*
89	REJECTED CLAIM FEES PAID
8C	MISSING/INVALID Facility ID
8E	MISSING/INVALID DUR/PPS Level Of Effort
90	Host Hung Up Host Disconnected
91	Host Response Error Response
92	System Unavailable/Host Unavailable
95	Time Out
96	Scheduled Downtime
97	Payer Unavailable
98	Connection To Payer Is Down
99	Host Processing Error
A9	MISSING/INVALID Transaction Count
AA	PATIENT SPENDDOWN NOT MET
AB	DATE WRITTEN IS AFTER DATE FILLED
AC	DRUG NOT COVERED, NON-PARTICIPATING MANUFACTURER
AD	BILLING PROVIDER NOT ELIGIBLE TO BILL THIS CLAIM TYPE
AE	QMB (QUALIFIED MEDICARE BENEFICIARY) - BILL MEDICARE
AF	PATIENT ENROLLED UNDER MANAGED CARE
AG	DAYS SUPPLY LIMITATION FOR NDC
AH	UNIT DOSE PACKAGING ONLY PAYABLE FOR NURSING HOME MEMBERS
AJ	GENERIC DRUG REQUIRED
AK	MISSING/INVALID Software Vendor/Certification ID
AM	MISSING/INVALID Segment Identification
B2	MISSING/INVALID Service Provider ID Qualifier
BE	MISSING/INVALID Professional Service Fee Submitted
CA	MISSING/INVALID PATIENT FIRST NAME
CB	MISSING/INVALID PATIENT LAST NAME
CC	MISSING/INVALID CARDHOLDER FIRST NAME
CD	MISSING/INVALID CARDHOLDER LAST NAME
CE	MISSING/INVALID HOME PLAN
CF	MISSING/INVALID EMPLOYER NAME
CG	MISSING/INVALID EMPLOYER STREET ADDRESS
CH	MISSING/INVALID EMPLOYER CITY ADDRESS
CI	MISSING/INVALID EMPLOYER STATE ADDRESS
CJ	MISSING/INVALID EMPLOYER ZIP CODE
CK	MISSING/INVALID EMPLOYER PHONE NUMBER

Reject Code	*Explanation*
CL	MISSING/INVALID EMPLOYER CONTACT NAME
CM	MISSING/INVALID PATIENT STREET ADDRESS
CN	MISSING/INVALID PATIENT CITY ADDRESS
CO	MISSING/INVALID PATIENT STATE ADDRESS
CP	MISSING/INVALID PATIENT ZIP CODE
CQ	MISSING/INVALID PATIENT PHONE NUMBER
CR	MISSING/INVALID CARRIER ID NUMBER
CT	MISSING/INVALID PATIENT SOCIAL SECURITY NUMBER
CW	MISSING/INVALID Alternate ID
CX	MISSING/INVALID Patient ID Qualifier
CY	MISSING/INVALID Patient ID
CZ	MISSING/INVALID Employer ID
DC	MISSING/INVALID Dispensing Fee Submitted
DN	MISSING/INVALID Basis Of Cost Determination
DP	MISSING/INVALID DRUG TYPE OVERRIDE
DQ	MISSING/INVALID USUAL AND CUSTOMARY
DR	MISSING/INVALID DOCTORS LAST NAME
DS	MISSING/INVALID POSTAGE AMOUNT CLAIMED
DT	MISSING/INVALID UNIT DOSE INDICATOR
DU	MISSING/INVALID GROSS AMOUNT DUE
DV	MISSING/INVALID OTHER PAYOR AMOUNT
DW	MISSING/INVALID BASIS OF DAYS SUPPLY DETERMINATION
DX	MISSING/INVALID PATIENT PAID AMOUNT
DY	MISSING/INVALID DATE OF INJURY
DZ	MISSING/INVALID CLAIM/REFERENCE ID NUMBER
E1	MISSING/INVALID ALTERNATE PRODUCT TYPE
E2	MISSING/INVALID ALTERNATE PRODUCT CODE
E3	MISSING/INVALID INCENTIVE AMOUNT SUBMITTED/PPS FEE SUBMITTED
E4	MISSING/INVALID DUR CONFLICT/REASON FOR SERVICE CODE
E5	MISSING/INVALID DUR INTERVENTION/PROFESSIONAL SERVICE CODE
E6	MISSING/INVALID DUR OUTCOME/RESULT OF SERVICE CODE
E7	MISSING/INVALID METRIC DECIMAL QUANTITY
E8	MISSING/INVALID OTHER PAYOR DATE
E9	MISSING/INVALID Provider ID
EA	MISSING/INVALID Originally Prescribed Product/Service Cod
EB	MISSING/INVALID Originally Prescribed Quantity

Reject Code	*Explanation*
EC	MISSING/INVALID COMPOUND INGREDIENT COMPONENT COUNTER NUMBER
ED	MISSING/INVALID COMPOUND INGREDIENT METRIC DECIMAL QUANTITY
EE	MISSING/INVALID COMPOUND INGREDIENT DRUG COST
EF	MISSING/INVALID COMPOUND DOSAGE FORM DESCRIPTION CODE
EG	ISSING/INVALID COMPOUND DISPENSING UNIT FORM INDICATOR
EH	MISSING/INVALID COMPOUND ROUTE OF ADMINISTRATION CODE
EJ	MISSING/INVALID Originally Prescribed Product/Service ID
EK	MISSING/INVALID Scheduled Prescription ID Number
EM	MISSING/INVALID Prescription/Service Reference Number Qua
EN	MISSING/INVALID Associated Prescription/Service Reference
EP	MISSING/INVALID Associated Prescription/Service Date
ER	MISSING/INVALID Procedure Modifier Code
ET	MISSING/INVALID Quantity Prescribed
EU	MISSING/INVALID Prior Authorization Type Code
EV	MISSING/INVALID Prior Authorization Number Submitted
EW	MISSING/INVALID Intermediary Authorization Type ID
EX	MISSING/INVALID Intermediary Authorization ID
EY	MISSING/INVALID Provider ID Qualifier
EZ	MISSING/INVALID Prescriber DEA Qualifier
FO	MISSING/INVALID Plan ID
GE	MISSING/INVALID Percentage Sales Tax Amount Submitted
H1	MISSING/INVALID Measurement Time
H2	MISSING/INVALID Measurement Dimension
H3	MISSING/INVALID Measurement Unit
H4	MISSING/INVALID Measurement Value
H5	MISSING/INVALID Primary Care Provider Location Code
H6	MISSING/INVALID DUR Co-Agent ID
H7	MISSING/INVALID Other Amount Claimed Submitted Count
H8	MISSING/INVALID Other Amount Claimed Submitted Qualifier
H9	MISSING/INVALID Other Amount Claimed Submitted
HA	MISSING/INVALID Flat Sales Tax Amount Submitted
HB	MISSING/INVALID Other Payer Amount Paid Count
HC	MISSING/INVALID Other Payer Amount Paid Qualifier
HD	MISSING/INVALID Dispensing Status
HE	MISSING/INVALID Percentage Sales Tax Rate Submitted
HF	MISSING/INVALID Quantity Intended To Be Dispensed

Reject Code	*Explanation*
HG	MISSING/INVALID Days Supply Intended To Be Dispensed
HN	MISSING/INVALID Patient E-Mail Address 35?
J9	MISSING/INVALID DUR Co-Agent ID Qualifier
JE	MISSING/INVALID Percentage Sales Tax Basis Submitted
KE	MISSING/INVALID Coupon Type
M1	PATIENT NOT COVERED IN THIS AID CATEGORY
M2	MEMBER LOCKED IN
M3	HOST PA/MC ERROR
M4	PRESCRIPTION NUMBER/TIME LIMIT EXCEEDED
M5	REQUIRES MANUAL CLAIM
M6	Host Eligibility Error
M7	Host Drug File Error
M8	Host Provider File Error
ME	MISSING/INVALID Coupon Number
MZ	Error Overflow
NE	MISSING/INVALID Coupon Value Amount
NN	TRANSACTION REJECTED AT SWITCH OR INTERMEDIARY
NP	MISSING/INVALID Other Payer-Patient Responsibility Amount
NQ	MISSING/INVALID Other Payer-Patient Responsibility Amount
NR	MISSING/INVALID Other Payer-Patient Responsibility Amount
NV	MISSING/INVALID Delay Reason Code
NX	MISSING/INVALID Submission Clarification Code Count
P1	Associated Prescription/Service Reference Number Not Foun
P2	Clinical Information Counter Out Of Sequence
P3	Compound Ingredient Component Count Does Not Match
P4	Coordination Of Benefits/Other Payments Count Does Not Ma
P5	Coupon Expired
P6	Date Of Service Prior To Date Of Birth
P7	Diagnosis Code Count Does Not Match Number Of Repetitions
P8	DUR/PPS Code Counter Out Of Sequence
P9	Field Is Non-Repeatable
PA	PA EXHAUSTED/NOT RENEWABLE
PB	Invalid Transaction Count For This Transaction Code
PC	MISSING/INVALID Request Claim Segment
PD	MISSING/INVALID Request Clinical Segment
PE	MISSING/INVALID Request Coordination Of Benefits

Reject Code	*Explanation*
PF	MISSING/INVALID Request Compound Segment
PG	MISSING/INVALID Request Coupon Segment
PH	MISSING/INVALID Request DUR/PPS Segment
PJ	MISSING/INVALID Request Insurance Segment
PK	MISSING/INVALID Request Patient Segment
PM	MISSING/INVALID Request Pharmacy Provider Segment
PN	MISSING/INVALID Request Prescriber Segment
PP	MISSING/INVALID Request Pricing Segment
PR	MISSING/INVALID Request Prior Authorization Segment
PS	MISSING/INVALID Transaction Header Segment
PT	MISSING/INVALID Request Worker's Compensation Segment
PV	Non-Matched Associated Prescription/Service Date
PW	Non-Matched Employer ID
PX	Non-Matched Other Payer ID
PY	Non-Matched Unit Form/Route of Administration
PZ	Non-Matched Unit Of Measure To Product/Service ID
R1	Other Amount Claimed Submitted Count Does Not Match Numbe
R2	Other Payer Reject Count Does Not Match Number Of Repetit
R3	Procedure Modifier Code Count Does Not Match Number Of Re
R4	Procedure Modifier Code Invalid For Product/Service ID
R5	Product/Service ID Must Be Zero When Product/Service ID Q
R6	Product/Service Not Appropriate For This Location
R7	Repeating Segment Not Allowed In Same Transaction
R8	Syntax Error
R9	Value In Gross Amount Due Does Not Follow Pricing Formula
RA	PA Reversal Out Of Order
RB	Multiple Partials Not Allowed
RC	Different Drug Entity Between Partial & Completion
RD	Mismatched Cardholder/Group ID-Partial To Completion
RE	MISSING/INVALID Compound Product ID Qualifier
RF	Improper Order Of Dispensing Status Code On Partial Fil
RG	MISSING/INVALID Associated Prescription/service Reference
RH	MISSING/INVALID Associated Prescription/Service Date On C
RJ	Associated Partial Fill Transaction Not On File
RK	Partial Fill Transaction Not Supported
RM	Completion Transaction Not Permitted With Same Date Of S

Reject Code	*Explanation*
RN	Plan Limits Exceeded On Intended Partial Fill Values
RP	Out Of Sequence P Reversal On Partial Fill Transaction
RS	MISSING/INVALID Associated Prescription/Service Date On P
RT	MISSING/INVALID Associated Prescription/Service Reference
RU	Mandatory Data Elements Must Occur Before Optional Data E
RV	Multiple Reversals Per Transmission Not Supported
SE	MISSING/INVALID Procedure Modifier Code Count
TE	MISSING/INVALID Compound Product ID
UE	MISSING/INVALID Compound Ingredient Basis Of Cost Determi
VE	MISSING/INVALID Diagnosis Code Count
WE	MISSING/INVALID Diagnosis Code Qualifier
XE	MISSING/INVALID Clinical Information Counter
ZE	MISSING/INVALID Measurement Date

Appendix I – Field Edits

Edit Number	*Edit Type*	*Edit Description*
0101	C	Member ID not on file
0102	N	Member not enrolled in HMO on date of service
0102	N	Member not enrolled in HMO on date of service
0103	C	Member ID missing
0104	N	Member not eligible on date of service
0104	N	Member not eligible on date of service
0105	C	Member last name missing
0106	N	First 5 characters of last name do not match name on file
0107	C	Member first name missing
0108	N	Proc/Diag code indicates delivery, but enrollee file shows
0109	N	Proc/Diag code indicates delivery, but enrollee file shows
0201	N	Billing provider not certified on date of service
0201	N	Billing provider not certified on date of service
0202	C	Bill Prov ID required for enc type I or O or Perf ID null and
0203	C	Billing provider id cannot be HMO base payee ID
0204	C	Billing provider id not on file
0205	N	First 2 char of Billing provider name do not match name on file
0206	C	Billing provider name required if Billing provider id exists
0207	C	Billing provider ID cannot be a billing service
0208	C	Performing Provider NPI not on file
0209	N	Performing provider not certified on date of service
0209	N	Performing provider not ertified on date of service
0210	N	Valid Performing or Billing Provider ID is required if data
0211	C	Performing Provider NPI cannot be HMO base payee ID
0212	C	Performing provider name required if Performing Provider NPI
0213	N	First 2 char of performing provider name do not match name on file
0215	C	Facility name/ID required if Data Source = 2,3 and Bill/Perf
0216	C	Bill prov id must be in the hospital or nursing home ID range

Edit Number	*Edit Type*	*Edit Description*
0301	C	Place of service required for encounter type M and D
0302	C	Place of service not on file
0303	N	Type of service missing on medical encounter type
0304	N	Type of service not on file
0305	C	Proc code required if encounter type = M, I or O and Rev
0306	C	Proc code required if encounter type = D
0307	C	Procedure code not on file
0308	C	Mod 1 not on file; not part of HCPCS code set or
0309	C	Mod 2 not on file; not part of HCPCS code set or
0310	C	Rev code required if encounter type M, I or O and Proc code
0311	C	Revenue code not on file
0313	C	Procedure code required if data source = 2 or 3
0314	C	Mod 3 not on file; not part of HCPCS code set or
0315	C	Mod 4 not on file; not part of HCPCS code set or
0316	N	Procedure Code for DOS submitted is not in the national
0401	C	Principle Diagnosis code is required for encounter type I, O,
0402	C	2nd Diagnosis code not on file
0403	C	2nd Diagnosis code present with no principle diagnosis code
0404	C	3rd Diagnosis code not on file
0405	C	3rd Diagnosis code present with no 2nd diagnosis code
0406	C	4th Diagnosis code not on file
0407	C	4th Diagnosis code present with no 3rd diagnosis code
0408	C	5th Diagnosis code not on file
0409	C	5th Diagnosis code present with no 4th diagnosis code
0410	C	6th Diagnosis code not on file
0411	C	6th Diagnosis code present with no 5th diagnosis code
0412	C	7th Diagnosis code not on file
0413	C	7th Diagnosis code present with no 6th diagnosis code
0414	C	8th Diagnosis code not on file
0415	C	8th Diagnosis code present with no 7th diagnosis code
0416	C	9th Diagnosis code not on file
0417	C	9th Diagnosis code present with no 8th diagnosis code
0418	C	E-diagnosis codes cannot be used as principle diagnosis
0419	C	Principle Diagnosis code not on file
0420	C	10th Diagnosis code not on file
0421	C	10th Diagnosis code present with no 9th diagnosis code
0422	C	11th Diagnosis code not on file
0423	C	11th Diagnosis code present with no 10h diagnosis code

Edit Number	*Edit Type*	*Edit Description*
0424	C	12th Diagnosis code not on file
0425	C	12th Diagnosis code present with no 11th diagnosis code
0426	C	13th Diagnosis code not on file
0427	C	13th Diagnosis code present with no 12th diagnosis code
0428	C	14th Diagnosis code not on file
0429	C	14th Diagnosis code present with no 13th diagnosis code
0430	C	15th Diagnosis code not on file
0431	C	15th Diagnosis code present with no 14th diagnosis code
0432	C	16th Diagnosis code not on file
0433	C	16th Diagnosis code present with no 15th diagnosis code
0434	C	17th Diagnosis code not on file
0435	C	17th Diagnosis code present with no 16th diagnosis code
0436	C	18th Diagnosis code not on file
0437	C	18th Diagnosis code present with no 17th diagnosis code
0501	C	Admission diagnosis not on file
0502	C	Admission diagnosis required when encounter type is
0503	C	Principle ICD procedure code not on file
0504	C	First other ICD procedure code not on file
0505	C	Second other ICD procedure code not on file
0506	C	Third other ICD procedure code not on file
0507	C	Fourth other ICD procedure code not on file
0508	C	Fifth other ICD procedure code not on file
0509	C	Admission type not on file
0510	C	Admission type required when encounter type is Inpatient
0511	C	Admission source not on file
0512	C	Patient status code not on file
0513	C	Patient status code required when encounter type is
0514	C	Admission date required when encounter type is Inpatient
0515	C	Admission Date invalid
0516	C	Admission date must be <= submission date
0517	C	Admission date must be <= from date of service
0518	C	Value code 1 not on file
0519	C	Value amount 1 must be >0 and value code 1 required
0520	C	Value code 2 not on file
0521	C	Value amount 2 must be >0 and value code 2 required
0522	C	Value code 3 not on file
0523	C	Value amount 3 must be >0 and value code 3 required
0524	C	Value code 4 not on file

Edit Number	*Edit Type*	*Edit Description*
0525	C	Value amount 4 must be >0 and value code 4 required
0526	C	Occurrence code 1 not on file
0527	C	Occurrence date 1 present without an occurrence code 1
0528	C	Occurrence Date 1 invalid
0529	C	Occurrence date 1 must be >= 01-01-1999
0530	C	Occurrence code 2 not on file
0531	C	Occurrence date 2 present without an occurrence code 2
0532	C	Occurrence Date 2 invalid
0533	C	Occurrence date 2 must be >= 01-01-1999
0534	C	Occurrence code 3 not on file
0535	C	Occurrence date 3 present without an occurrence code 3
0536	C	Occurrence Date 3 invalid
0537	C	Occurrence date 3 must be >= 01-01-1999
0538	C	Occurrence code 4 not on file
0539	C	Occurrence date 4 present without an occurrence code 4
0540	C	Occurrence Date 4 invalid
0541	C	Occurrence date 4 must be >= 01-01-1999
0542	C	Condition code 1 not on file
0543	C	Condition code 2 not on file
0544	C	Condition code 3 not on file
0545	C	Condition code 4 not on file
0701	C	HMO ID missing
0702	C	HMO ID does not match HMO ID in File name
0703	C	Record Type missing
0704	C	Required fields missing for Reversal record type
0705	C	Record type invalid
0706	C	Invalid ASCII characters or Alpha in numeric fields
0707	C	Incorrect record length
0708	C	RIN is missing
0709	C	Reversal RIN does not have an original to reverse
0710	C	Submission exceeded max loading edit failures - reject

Edit Number	*Edit Type*	*Edit Description*
0801	C	Prescription (RX) Date is invalid
0802	C	Prescription date must be <= submission date
0803	C	Fill date must be within 367 days of the prescribed date
0804	C	Prescription date required for encounter type = P
0805	C	Fill Date is invalid
0806	C	Fill date required for encounter type = P
0807	C	Fill date must be <= submission date
0808	C	Fill date must be >= prescription date
0809	C	Fill date must be >= 01-01-1999
0810	N	NDC not on file
0811	C	NDC required if encounter type = pharmacy
0812	C	Days supply required must be > 0 and < or = to 100 for
0813	N	Prescriber DEA number not on file
0814	C	Prescriber DEA required if encounter type = Pharmacy
0815	C	Prescription number required if encounter type = Pharmacy
0817	C	Refill indicator required if encounter type = Pharmacy
0818	C	Unit dose value not on file
0819	C	DAW value not on file
0820	C	Unit dose required for encounter type = P
0821	C	DAW (dispensed as written) required for encounter type = P
0822	C	NDC must be 11 digits and numeric for ET=(P) Pharmacy.
0823	N	NDC Fill Date not between the availabilty date and the
0824	C	Pharmacy records are not accepted for fill dates =>
0901	C	From date of service must be >= 01-01-1999 for encounter
0902	C	From date of service required if encounter type = I, D, O, M
0903	C	From Date of Service invalid
0904	C	From date of service must be <= submission date
0906	C	To date of service must be >= From date of service
0907	C	To date of service required if encounter type = I
0908	C	To Date of Service invalid
0909	C	To date of service must be <= submission date

Edit Number	*Edit Type*	*Edit Description*
1001	N	DRG code not on file (disabled)
1002	C	Quantity is required for record type = O
1003	C	Quantity must be > 0.009 for record type = O
1004	C	Charges are required for record type = O
1005	N	Charges must be > 0 for original record type unless cap or
1006	N	Quantity must be < or = to 1000 for encounter type P
1007	N	Charges are $0.00 for enc type = O
1501	C	Emergency services indicator not on file
1502	C	Emergency indicator required for encounter type = M
1503	C	Healthcheck indicator not on file
1504	C	Healthcheck indicator required for encounter type = M or D
1505	C	Family planning indicator not on file
1506	C	Family planning indicator required for encounter type = M
1601	C	ANSI/NCPDP code 1 not on file
1602	C	ANSI/NCPDP code 2 not on file
1603	C	ANSI/NCPDP code 3 not on file
1604	C	ANSI/NCPDP code 4 not on file
1701	C	Encounter type required for all detail records
1702	C	Encounter type not on file
1704	C	Data source not on file
1708	C	Data source required for all encounter types
1710	C	Process date must be <= submission date
1711	C	Process date required for all encounter types
1712	C	Process Date invalid

Edit Number	*Edit Type*	*Edit Description*
9001	C	Header record incorrect length
9002	C	Header record fields not ASCII or alpha in numeric fields
9003	C	Header record HMO ID does not match file name
9004	C	No detail records submitted
9005	C	Header record HMO ID missing
9006	C	HMO ID in file name is invalid
9007	C	Header submission date missing/invalid
9009	C	Header submission date must be <= EDS received date
9010	C	Header beginning process date missing/invalid
9012	C	Header beginning process date must be < submission date
9013	C	Header beginning process date must be < ending process
9014	C	Header begin process date must be > ending process date
9015	C	Header ending process date missing/invalid
9017	C	Header ending process date must be <= submission date
9019	C	Header ending process date must be > ending process date
9020	C	Header Number of records transmitted missing/invalid
9021	C	Incorrect Zip file name.Please see Appendix C of the
9022	C	Number of records transmitted not equal to header record

Appendix K – Encounter Data Attestation

Attestation is the method used to communicate that the HMO is satisfied with their encounter data submission. Attestations are considered to be the final acknowledgement of submitted encounters for a given period, and are the only files that will be used to price encounters. The Encounter Data Attestation form will be submitted to the State each quarter. Any adjustments to the encounter data will need to be made in subsequent submissions.

Submitting the Attestation Form

- The HMO Chief Executive Officer, the Chief Financial Officer, or their designee must attest to the truthfulness, accuracy, and completeness of all data submitted to the Department at the time of submission.

- Submit the attestation form to the Division of Health Care Access and Accountability, Bureau of Benefits Management. Submit the form either by fax or mail. The fax number is 608-266-1096 The mail address is:

  DHS
  DHCAA – Bureau of Benefits Management
  1 West Wilson Street
  PO Box 309
  Madison WI 53701-0309
  Attention: Ashley Davis

- Please keep a copy for your files.

DEPARTMENT OF HEALTH SERVICES
STATE OF WISCONSIN
Division of Health Care Access and Accountability
P.L. 104-191
DHCAA XXXXXX (07/08)

Wisconsin ForwardHealth Managed Care

Attestation Form

ATTESTATION

I, _____, have reviewed the following data:
(Name, Title, Organization)

Check one:

- ☐ Encounter Data for (quarter)_____(year) 200__.
- ☐ AIDS/Vent Report for (quarter)_____for (year) 200__.
- ☐ FQHC/RHC Report (annually)_____(year) 200____.
- ☐ Other _____ (Specify Report) (year) 200____.

I hereby attest and affirm to the best of my knowledge that all data being submitted is accurate, complete and truthful at the time of submission and that no material facts have been omitted. I furthermore attest and affirm that no material facts were omitted from this form. I understand that state or federal authorities may inspect all claims, records or documents pertaining to the provision of these services.

_____
(Signature) (Date)

_____
(Print Name) (Print Date)